April 2020: 62:3
Pages 81– 120

Digital storytelling and dialogue to support culturally safe health care for Indigenous patients

IN THIS ISSUE

COVID-19 pandemic information and resources

Assessing the impact of a nursing model of care on rheumatology practice patterns and patient satisfaction

Changing drug policies: Ending the crisis

Group medical practice is the natural evolution of medicine

bcmj.org

Doctors of BC

Links and resources for COVID-19

Doctors of BC is taking active steps to support members with respect to coronavirus (COVID-19). Work includes advocacy on behalf of physicians with government, the provincial health officer, and health authorities, as well as ensuring members have access to appropriate benefits and insurance.

An information resource from Doctors of BC, updated regularly:

www.doctorsofbc.ca/covid-19

This page has information on:

- COVID-19 changes to billing
- Virtual care support
- President's Letters
- Insurance updates
- Support for physicians feeling stress during COVID-19

For questions or concerns about COVID-19, contact us directly at **covid19@doctorsofbc.ca.**

April 2020
Volume 62 | No. 3
Pages 81–120

Group medical practice, believes Dr Mark Elliott, is the natural evolution of medicine. His article begins on page 106.

85 Editorials
Whatever is popular is wrong and other pandemic reflections, **David Esler, MD**
Using our position to spread kindness and acceptance, **David Richardson, MD**

87 President's Comment
Physician wellness, **Kathleen Ross, MD**

88 Letters
E-cigarettes and youth health, **Aki Nilanga Bandara, Mehara Seneviratne, Senara Wanniarachchi, BSc, Vahid Mehrnoush, MD**
HLA-B*58:01 screening prior to the prescription of allopurinol, **Marisa Ponzo, MD-PhD, Jan Dutz, MD**

89 BCCDC
COVID-19: Responding to an emerging respiratory pathogen, **Alexis Crabtree, MD, Alexandra Choi, MD, Althea Hayden, MDCM, Réka Gustafson, MD, Bonnie Henry, MD**

90 College Library
Rural medicine and the College Library, **Paula Osachoff**

91 COHP
Changing drug policies: What do we need to end this heartbreaking crisis? **Dereck Chang, MD**

CLINICAL

92 Guest Editorial: In search of collaboration between Indigenous traditional practices and Western medicine, **Kendall Ho, MD, Gerry Oleman**

94 Digital storytelling and dialogue to support culturally safe health care for Indigenous patients in British Columbia, **Antonia Hyman, MSc, Elizabeth Stacy, MA, Kaitlin Atkinson, MPaH, Helen Novak Lauscher, PhD, Jon Rabeneck, Gerry Oleman, Penny Cooper, MALT, Wendy Young, PhD, Carol Kellman, BScN, Kendall Ho, MD**

Contents continued on page 84

Environmental impact

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

- Supporting members who wish to read online with an e-subscription to 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

Postage paid at Vancouver, BC. Canadian Publications Mail, Product Sales Agreement #40841036. Return undeliverable copies to *BC Medical Journal,* 115–1665 West Broadway, Vancouver, BC V6J 5A4; tel: 604 638-2815; email: journal@doctorsofbc.ca.

Advertisements and enclosures carry no endorsement of Doctors of BC or *BCMJ*.

© *British Columbia Medical Journal*, 2020. All rights reserved. No part of this journal may be reproduced, stored in a retrieval system, or transmitted in any form or by any other means—electronic, mechanical, photocopying, recording, or otherwise—without prior permission in writing from the *British Columbia Medical Journal*. To seek permission to use *BCMJ* material in any form for any purpose, send an email to journal@doctorsofbc.ca or call 604 638-2815.

Statements and opinions expressed in the *BCMJ* reflect the opinions of the authors and not necessarily those of Doctors of BC or the institutions they may be associated with. Doctors of BC does not assume responsibility or liability for damages arising from errors or omissions, or from the use of information or advice contained in the *BCMJ*.

The *BCMJ* reserves the right to refuse advertising.

ON THE COVER
Digital storytelling and dialogue to support culturally safe health care for Indigenous patients
The integration of Indigenous healing practices in the province's health care system is being facilitated by a video that features traditional practitioners and Western medical professionals. See pages 92 to 97.

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.

Print: The *BCMJ* is distributed monthly, other than in January and August.

Web: Each issue is available at www.bcmj.org.

Subscribe to print: Email journal@doctorsofbc.ca.
Single issue: $8.00
Canada per year: $60.00
Foreign (surface mail): $75.00

Subscribe to notifications:
To receive the table of contents by email, visit www.bcmj.org and click on "Free e-subscription."

Prospective authors: Consult the "Guidelines for Authors" at www.bcmj.org for submission requirements.

Editor
David R. Richardson, MD

Editorial Board
Jeevyn Chahal, MD
David B. Chapman, MBChB
Brian Day, MB
Caitlin Dunne, MD
David J. Esler, MD
Yvonne Sin, MD
Cynthia Verchere, MD

Managing editor
Jay Draper

Associate editor
Joanne Jablkowski

Senior editorial and production coordinator
Kashmira Suraliwalla

Copy editor
Barbara Tomlin

Proofreader
Ruth Wilson

Web and social media coordinator
Amy Haagsma

Cover concept and art direction, Jerry Wong, Peaceful Warrior Arts

Design and production
Laura Redmond, Scout Creative

Printing
Mitchell Press

Advertising
Kashmira Suraliwalla
604 638-2815
or journal@doctorsofbc.ca

ISSN: 0007-0556
Established 1959

Dr David Obert took additional training in prehospital and transport medicine with BC Emergency Health Services; his article about his experiences begins on page 103. Pictured: Sergeant Ashley Barker and Sergeant Scott Hoadley, both members of 442 Transport and Rescue Squadron, participating in a medical exercise at HMCS Quadra in Comox in the spring of 2019.

Contents continued from page 83

98 Assessing the impact of a nursing model of care on rheumatology practice patterns and patient satisfaction in British Columbia, **J. Connell, BSc, J. Kur, MD, J.H. Gurmin, LPhil**

103 Special Feature
"That Others May Live": Two weeks with the Joint Rescue Coordination Centre, **David A. Obert, MD**

106 Premise
Group medical practice is the natural evolution of medicine, **Mark Elliott, MD**

108 News
- Register now for Business Cost Premium
- Benefits of accelerated surgery with hip fracture
- Physical activity for prostate cancer patients and its effect on tumors
- Doctors of BC governance and committee reporting structure
- What patients lie to their doctors about, and why

111 Obituaries
Dr Hans Albert Witt
Dr Barry King Cutler

112 CME Calendar

114 Billing Tips
Why become a medical inspector? **Nick Szpakowicz, MD**

115 Guidelines for Authors

116 Classifieds

Whatever is popular is wrong and other pandemic reflections

24 March 2020

Medical practice is challenging, never more than during a pandemic. In such times we turn to Sir William Osler for wisdom and perspective.

In 1896, Osler observed that "Humanity has but three great enemies: fever, famine, and war; of these by far the greatest, by far the most terrible, is fever." Before his death at the age of 70 in 1919, Osler had lived through the potato famine, which dispatched some 1 million souls in Ireland; World War I, which claimed 10 million soldiers (including his only son, Revere Osler) and an equal number of civilians; and the Spanish flu, which is purported to have killed 17 to 100 million worldwide.

An expert in all facets of medicine, Osler regarded pneumonia as the "old man's friend." "Pneumonia may well be called the friend of the aged. Taken off by it in an acute, short, not often painful illness, the old man escapes those 'cold gradations of decay' so distressing to himself and to his friends." Osler himself succumbed to postpneumonic empyema 2 years after Revere fell at Passchendaele.

One wonders how Osler would have viewed the current pandemic, and the unprecedented worldwide response, on the recommendation of the world's most distinguished public health physicians.

Osler was attuned to the diversity of disease: "Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease."

Not surprisingly, each epidemic behaves as a "complex system" to use today's parlance. While Spanish flu (N1H1) and COVID-19 (novel coronavirus) are both highly contagious respiratory viruses, they behave differently. The latter has proved more insidious: significant transmission apparently occurs before symptoms peak. While the mortality of both pathogens is likely 2.5% (this will never be known with any certainty), they target different age groups. Spanish flu had a tragic predilection for healthy young adults, while COVID-19 preferentially targets frail elderly people.

The most striking feature of pandemics is their unpredictability and inexplicability. The Spanish flu peaked abruptly in November 1918 at the end of World War I then died out after a brief peak in the spring of 1919. The SARS (novel coronavirus) epidemic lasted only 6 months, peaking in the spring of 2013 then disappearing, claiming 774 lives worldwide. MERS (camel flu), with a striking case fatality rate of 35%, emerged in 2012 and has never disappeared. Fortunately, it has to date claimed only 900 lives.

In short, this current pandemic, in keeping with its predecessors, is proving to be fickle, capricious, and utterly unpredictable.

COVID-19 was identified in China in December 2019, claiming 3300 lives—0.00024% of China's 1. 4 billion citizens—then quickly died out in the world's most populous country. Neighboring Asian countries have been comparatively fortunate with only South Korea (120) tallying more than 100 deaths.

In the mid-east, Iran (1934) is the only country to have recorded more than 100 deaths. Western Europe has emerged as the disease epicentre with the death toll in Italy reaching 7000 and several other countries counting over 100 deaths including Spain (2808), France (1100), UK (422), Netherlands (276), Germany (157), Belgium, and Switzerland (122 each).

In comparison, North America has been fortunate, with some 700 deaths in the US and very few in Canada (26) and Mexico (6).

Defying understanding, COVID-19 has to date essentially spared Africa, South America, Russia, and India; none of these population centres have reported 100 deaths. Also puzzling and inexplicable has been the staggeringly divergent mortality of COVID-19 in neighboring countries. Italy's eastern neighbor, Slovenia, has announced 4 deaths, while Austria has had 28.

In short, this current pandemic, in keeping with its predecessors, is proving to be fickle, capricious, and utterly unpredictable.

Much more predictable has been the medico-political response. In Canada and the US, initial complacency has given way to a cry for total war against the virus. Measures that would have been inconceivable 2 months ago—border closures, the shuttering of business and public institutions, and banning of all public gatherings, have been universally championed by the medical establishment, with politicians and the public joining enthusiastically in a deafening chorus: "We must do more!"

This unprecedented response cannot help but give senior physicians pause. Osler stated, "The greater the ignorance the greater the dogmatism." Over the course of a long career, who among us has not witnessed prominent physicians alternately espouse and then condemn medical interventions with great fervor? In the 1980s, surgeons insisted that physicians withhold opiates from patients with abdominal pain prior to their examination—giving morphine would preclude accurate diagnosis. In the 1990s, medical thought leaders exhorted us to provide opioids to those with chronic pain—addiction was a myth, and denying patients relief from pain tantamount to malpractice. Liberal opioid prescribing became a cri du coeur touted by virtuous and compassionate physicians—few dared to question a dogma that proved fatally flawed.

In parallel, few physicians—a notable exception being Stanford epidemiologist John Ioannidis—have dared publicly question the wisdom of the North American public health response to COVID-19. Does enforcing social

isolation and suspending access to routine medical and hospital care in the event we are overrun by patients requiring ventilation in the ICU serve the greater good, given the mercifully low number of serious cases seen in Canada to date?

I suspect that Oscar Wilde—never one to run with the crowd—would have responded, as he famously did when commenting on bad art: "Whatever is popular is wrong."

Such a skeptical view is unpalatable in trying times, as many others have observed. Former Prime Minister Kim Campbell noted that "An election is no time to discuss serious issues." The philosopher Bertrand Russell stated, "Neither a man nor a crowd nor a nation can be trusted to act humanely or to think sanely under the influence of a great fear." Perhaps Texas-born CBS anchor Dan Rather said it best: "Once the herd starts moving in one direction, it's very hard to turn it, even slightly."

In these trying times, Osler serves as a voice of wisdom and comfort. From his most famous essay, Aequanimitas:

> One of the first essentials in securing a good-natured equanimity is not to expect too much of the people amongst whom you dwell... Deal gently then with this deliciously credulous old human nature in which we work, and restrain your indignation, when you find your pet parson has triturates of the 1000th potentiality in his waistcoat pocket, or you discover accidentally a case of Warner's Safe Cure in the bedroom of your best patient. It must be that offences of this kind come, expect them, and do not be vexed. ■

—David J. Esler, MD

Information on COVID-19 from Doctors of BC, updated regularly:

www.doctorsofbc.ca/covid-19

Using our position to spread kindness and acceptance

"It was the best of times, it was the worst of times," begins Charles Dickens in his famous novel, *A Tale of Two Cities*, first published in 1859. I would like to think that human nature has gravitated more toward the best of times in the more than 160 years that have passed since this date.

Pink Shirt Day in BC took place on 26 February, marked by individuals wearing pink shirts as a statement against bullying. This tradition started in 2007 after a grade 9 student in Nova Scotia was bullied for wearing a pink shirt to school. In solidarity, other students started wearing similar shirts and within a few days almost the whole school was adorned in pink.

Every year on this day I sport a bright pink T-shirt with the words *Be Kind Brave and Awesome*.

Every year on this day I sport a bright pink T-shirt with the words *Be Kind Brave and Awesome* screened in big white letters on the front. My patients are used to my colorful wardrobe, but most of them realize wearing a pink T-shirt in February is unusual even for me. Some patients look at me suspiciously and I can tell they want to ask about it, but they bite their tongues for whatever reason. Other patients are aware of the significance of the shirt and acknowledge this good cause. A few, like one of my elderly patients, can't help themselves.

"Why are you wearing a pink shirt, Doctor?" she blurted out.

"It's for antibullying day Mrs Smith," I replied.

"Oh, I see," she accepted.

However, at the end of the patient encounter she suddenly queried, "I don't get it, what do you have against bowling?"*

I love the idea of a day dedicated to the fight against bullying, which I like to think we have been winning. But then a story highlighting the "worst of times" surfaced on social media and in the news. A video appeared in which an Australian boy, Quaden Bayles, who has a form of dwarfism, talks about wanting to die because of the incessant bullying he faces at school. Heartbreaking to watch, it was shared by his mother to show the anguish this negative behavior causes her son. In it she pleads for kindness in thought and action toward Quaden and others like him.

Sadness filled my heart as I thought about this boy and his struggle. It seemed like little had changed despite public campaigns and education. I remember being bullied as a youngster and on self-reflection, if I'm honest, at times I was the bully. What is it about human nature that leads to this less than admirable behavior? Thankfully, I was pulled from my dark ruminations by an outpouring of worldwide support for the young man (the best of times).

Numerous celebrities, including Hugh Jackman and comedian Brad Williams, who also has dwarfism, came out in support of the bullied boy. Apparently, Quaden loves rugby and was asked to lead an Australian all-star team out onto the field before a game. A GoFundMe page was started to send him to Disneyland, and it quickly built up to a few hundred thousand dollars. Quaden and his family, showing absolute class, declined the trip and instead plan to donate the money to anti-abuse and antibullying charities.

We can all do our part to end bullying. Physicians are still respected members of society (well at least most of you are), and through our patient interactions we can spread a message of kindness and acceptance, making stories like Quaden's a thing of the past. I sincerely hope this won't take 160 years. ■

—David R. Richardson, MD

**Who doesn't have a problem with bowling, by the way? I mean, really, how clean are those rented shoes?*

Physician wellness

"I shall not today attempt further to define [it]. . . but I know it when I see it."

—Justice Potter Stewart

While this quote applies to something much more graphic, I feel that it could also describe physician wellness. Wellness has a wide variety of definitions for physicians, many of which depend on our current state of physical and mental health, work pressures, family demands, and stage of career. How then do we figure out the different aspects of wellness and effectively address them to find the right solutions and improve the working and personal lives of physicians?

I know how important this is, and fortunately, work on this front is moving forward at a rapid pace. At the grassroots level across BC, divisions of family practice and medical staff associations support physician wellness champions (among other initiatives) who connect with their colleagues to strengthen health and wellness work. As well, the Specialist Services Committee has made addressing physician burdens, burnout, and wellness at the local level a new strategic priority. Each local initiative is unique in its approach (many of which are targeted at individual processes), and while their importance is valued by many, we must find system-wide solutions to tackle the problem at the source.

Doctors of BC's Physician Burdens survey of members revealed that a fair number of the pressures that physicians face fall well outside the individual physician's control and contribute to the moral injury that is driving burnout across our profession. Physicians reported working in environments with excessively high demands from clinical settings, administrators, and patients. In some cases, physicians are working in environments that are not physically safe and fail to meet the basic WorkSafeBC Occupational Health and Safety Regulations that, by law, apply to all workers in BC. Tremendous variation exists across clinical settings, which highlights the upstream system problems requiring an overarching approach.

In response to member identified priorities, the 2019 Physician Master Agreement generated a memorandum of agreement with our health authorities, titled Physical and Psychological Health and Safety, which is intended to ensure physician input to improve physical and psychological workplace health and safety for health care workers. In consultation with physician groups across BC, our governance bodies have committed to establishing occupational standards across all health authorities, as defined by the Canadian Standards Association (CSA). This is a complex issue. For those not aware of the CSA Standards, there are 13 workplace factors that it suggests addressing: organizational culture, psychological and social support, clear leadership with expectations, civility and respect, psychological demands, growth and development, recognition and reward, involvement and influence, workload management, engagement, balance, psychological protection, and protection of physical safety.

A fair number of the pressures that physicians face fall well outside the individual physician's control and contribute to the moral injury that is driving burnout across our profession.

Finding solutions that address the systemic pressures needs to begin with face-to-face meetings between administrators and physicians where honest and safe conversations about the barriers can take place and answers that respect the perspectives and capabilities of all parties are co-developed. Physicians cannot do this in isolation; neither should we leave our administrators to establish processes without our specific grassroots knowledge.

Other than the initiatives developed by Doctors of BC, medical staff associations, and divisions, a number of other systems-level solutions are in various stages of implementation, including work with ICBC, WorkSafeBC, and health authorities, among others. As well, through the Regional Physical/Psychological Health and Safety Working Group, Doctors of BC will now have representatives in provincial and regional structures to gather your input and to help establish processes that support physician-specific physical and psychological safety projects. These representatives need your participation, in whatever way you are able to engage, to provide an adequate foundation and inform new processes. Doctors of BC will be reaching out and I encourage everyone to contribute.

BC is not alone in recognizing the complexity and critical timing of this issue. The Canadian Medical Association Statement on Physician Health and Wellness (www.cma.ca/sites/default/files/2018-11/physician-health-wellness-statement-e.pdf) of 2018 established several principles for the consideration of physicians across Canada. The aspect that resonated with me the most was that regardless of the definition, physician wellness should be a shared responsibility and a quality indicator. For too long, we physicians have toiled in isolation, carrying our many burdens. The way forward is to share our loads and begin to truly and fully address the system pressures alongside those with the organizational prowess to make meaningful improvements. ■

—**Kathleen Ross, MD**
Doctors of BC President

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.

E-cigarettes and youth health

Tobacco products in all forms are highly addictive because they contain nicotine, one of the most addictive substances used by humans. High-nicotine content in e-cigarettes poses as a potentially disastrous innovation in the 21st century and a well-known public health threat to our vulnerable children's future and their overall health and well-being.

Even though we clearly know that the nicotine is addictive and poses significant challenges to smoking cessation, sophisticated social media campaigns tend to unduly discount the risks and overstate the benefits of e-cigarettes. Distorted risk perceptions are associated with adolescents' decisions to initiate e-cigarette use, decisions they will likely regret in adulthood.

We need Health Canada's sensible presence in e-cigarette prevention and control efforts, including federal government regulation over e-cigarette flavored products, online sales, and social marketing. We need creative strategies to put our children on a path to a healthy, tobacco-free lifestyle and ensure that young leaders influence future tobacco control policies in Canada and globally.[1-3]

E-cigarettes should carry health warnings like combustible tobacco, which could counteract misinformation suggesting that they are a less harmful and safer alternative to combustible tobacco. We should train student leaders to become peer counselors in their schools to help their peers to quit e-cigarettes. School administrators, teachers, parents, caregivers, and public health officials should build a meaningful partnership to address this issue in schools.

Every adolescent consultation is a golden opportunity for a "teachable moment,"[4] and engaging adolescents about their desire to change health behaviors and referring them to further support can make it more likely for them to make and sustain behavioral change.[5] Developing clinical guidelines incorporating the current best evidence to facilitate clinical decisions and gain more insight into the complex reality of e-cigarettes is of utmost importance.

—Aki Nilanga Bandara, Burnaby

—Mehara Seneviratne, Surrey

—Senara Wanniarachchi, BSc, Coquitlam

—Vahid Mehrnoush, MD, West Vancouver

References

1. Bandara AN. Understanding adolescent perception on e-cigarettes is vital. Am J Public Health 2016;106:e13.
2. Bandara AN, Jhauj R, Mehmoush V. The major causes of death in children. N Engl J Med 2019;380:1384-1385.
3. Bandara AN. The consultation of youth in the public health care policy-making process. Can J Public Health 2016;107:e216.
4. Cohen DJ, Clark EC, Larsen PJ, et al. Identifying teachable moments for health behavior counseling in primary care. Patient Educ Couns 2011;85(2):e8-15. www.ncbi.nlm.nih.gov/pmc/articles/PMC4389220.
5. Lawson PJ, Flocke SA. Teachable moments for health behavior change: A concept analysis. Patient Educ Couns 2009;76:25-30.

HLA-B*58:01 screening prior to the prescription of allopurinol

The health burden of gout continues to rise in Canada.[1] Allopurinol, a common urate-lowering medication used to treat gout, is associated with severe adverse cutaneous drug reactions (SCARs) in specific at-risk populations, primarily people of East Asian descent. SCARs include Stevens-Johnson syndrome, toxic epidermal necrolysis and drug reaction with eosinophilia and systemic symptoms, and lead to elevated morbidity/mortality and long-term sequelae. Two recent Canadian publications[2,3] have highlighted the importance of screening at-risk populations for the development SCARs. The American College of Rheumatology guidelines recommend screening East Asian patients for the *HLA-B*58:01* genotype prior to prescribing allopurinol, to eliminate the risk of SCARs in this population.[4,5] Unfortunately, *HLA-B*58:01* genotype testing is underutilized in British Columbia despite East Asians comprising a substantial proportion of the population.[2] Other risk factors for SCARs in individuals prescribed allopurinol include heart disease and chronic kidney disease.[3]

The cost-effectiveness of preventive HLA screening for East Asians prior to allopurinol has been established in various populations globally and this screening needs to be more widely adopted in Canada. In British Columbia, *HLA-B*58:01* genotype screening can be ordered by sending blood tests to BC Transplant, the laboratory in charge of HLA genotyping. Other therapeutic options for the control of hyperuricemia include feboxustat and uricosurics. We believe that not performing this test prior to the prescription of allopurinol may cause your Asian patients serious harm.

—Marisa Ponzo, MD-PhD, FRCPC
Vancouver

—Jan Dutz, MD, FRCPC
Vancouver

References

1. Rai SK, Aviña-Zubieta JA, McCormick N, et al. Trends in gout and rheumatoid arthritis hospitalizations in Canada from 2000 to 2011. Arthritis Care Res (Hoboken) 2017;69:758-762.
2. Ponzo MG, Miliszewski M, Kirchhof MG, et al. ***HLA-B*58:01*** genotyping to prevent cases of DRESS and SJS/TEN in East Asians treated with allopurinol—A Canadian missed opportunity. J Cutan Med Surg 2019;23:595-601.
3. Yokose C, Lu N, Xie H, et al. Heart disease and the risk of allopurinol-associated severe cutaneous adverse reactions: A general population-based cohort study. CMAJ 2019;191:E1070-E1077.
4. Khanna D, Fitzgerald JD, Khanna PP, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 1: Systematic non-pharmacologic and pharmacologic therapeutic approaches to hyperuricemia. Arthritis Care Res (Hoboken) 2012;64:1431-1446.
5. Khanna D, Khanna PP, Fitzgerald JD, et al. 2012 American College of Rheumatology guidelines for management of gout. Part 2: Therapy and anti-inflammatory prophylaxis of acute gouty arthritis. Arthritis Care Res (Hoboken) 2012;64:1447-1461.

COVID-19: Responding to an emerging respiratory pathogen

Clinicians in British Columbia have been responding to COVID-19, the novel coronavirus that originated in late 2019 in Wuhan, China. The virus subsequently spread to countries around the globe, prompting the World Health Organization to declare it a Public Health Emergency of International Concern. At the time of writing (28 February 2020), 83 324 cases have been reported, with the vast majority still in Mainland China. Fifty-one countries, including Canada, have reported imported cases, and a handful of countries, including Iran, Italy, and South Korea, are responding to local outbreaks. By the time this article is published, the global picture will likely look very different. This article describes the health system response to a novel pathogen as it emerges.

COVID-19 in British Columbia

As of 28 February 2020, testing of 1425 specimens has identified seven infections in BC, all in travelers or close contacts of travelers to an area with community transmission. The very small number of cases, all of which have a known source of infection, indicate that at the end of February 2020 there is little community transmission of COVID-19 in British Columbia. At this stage of the emergence of a new pathogen, containment measures can be effective.

How do we respond to an emerging respiratory pathogen?

On 31 December 2019, China reported an outbreak of pneumonia of unknown cause to the World Health Organization. At that time, the pathogen, the clinical spectrum of disease, and the populations at greatest risk were unknown. However, within 10 days, China identified the virus and published the viral genetic code. This enabled laboratories to quickly develop tests for the virus. The BC Centre for Disease Control (BCCDC) Public Health Laboratory was able to develop a test within 3 days, and then test the first specimen within 10 days. In the following month, testing protocols were developed and validated, and laboratories throughout BC had the ability to test for the virus. Public health monitored emerging research and epidemiology about COVID-19 in order to provide advice to the public and testing recommendations to clinicians.

During this period of an emerging disease, there is a great deal of information and misinformation, and recommendations change rapidly, often leading to uncertainty and concern. In British Columbia, the provincial health officer, your local medical health officers, and the BCCDC are committed to providing you with up-to-date information that is relevant to your community.

The risk of serious illness and death increases sharply in the seventh and eighth decades of life and in those with chronic conditions.

By the end of February, a great deal was learned about COVID-19. Information from the outbreak in China indicated that among those with a diagnosed illness, the majority (over 80%) of people have mild illness with recovery in about 2 weeks. Early data from outbreaks on cruise ships suggested that a substantial proportion of people with infection are asymptomatic. Children and adolescents appear to be relatively spared, and the risk of serious illness and death increases sharply in the seventh and eighth decades of life and in those with chronic conditions including cardiovascular and respiratory diseases, diabetes, and cancer. The case fatality rate, which is essential to know for both planning and response, remains difficult to estimate. In Hubei province, the epicentre of the epidemic, it is estimated to be 2% to 3%, while outside this area the case fatality rate is well below 1%. These estimates are likely to be refined by the time this article is published, as information becomes available about the rate of asymptomatic infections.

At the early stage of a new communicable disease, when there is no indication of community transmission, each individual case is managed using the core measures of public health: prompt identification and isolation of cases, contact tracing and management, and effective infection control practices in health care settings. At the same time, the health care system prepares for potential sustained local transmission.

How do we prepare for the possibility of sustained community transmission in BC?

In February, emergency operations centres (EOCs) were established at provincial, regional, and hospital levels to coordinate public health and clinical responses across the health care system and with government and community partners. These EOCs have the goal of preparing for additional cases and working to minimize disruption to the health care system. Clinicians across the health care system continue to respond to COVID-19: by identifying and managing potential cases, and by addressing patient concerns often fueled by the "infodemic" of news and social media information.

It is still possible that the massive and unprecedented efforts of the Chinese and other governments will be successful in containing the virus through quarantine and isolation, and

Continued on page 90

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

Rural medicine and the College Library

Internet access and online resources have come a long way to providing additional support for rural physicians. While using online databases, point-of-care tools, textbooks, and journals has never been easier, rural physicians still face high-stakes challenges in isolated settings. Emergency medicine, geriatrics, and obstetrics/gynecology are all possible parts of a rural physician's day, and the College Library has numerous ways for doctors to access the information they need.

This article is the opinion of the Library of the College of Physicians and Surgeons of BC and has not been peer reviewed by the BCMJ Editorial Board.

Most of the College Library's resources are online and available throughout the province 24 hours a day—use your CPSID and password to log in. A list of rural health journals that the College Library subscribes to is available at https://bit.ly/2u9J1o9. Additionally, the Library can send you any journal's table of contents, and source and deliver articles from almost any journal at no cost.

First Nations patients may feature in your practice, and we have books to help you provide your patients with informed and culturally sensitive care (visit https://bit.ly/3bOL9m7). Current online and print titles regarding rural health are available at https://bit.ly/39LQysu.

Most print books can be mailed to you anywhere in the province at no cost. We provide return, postage paid mailing labels; save the envelope that your book arrived in, and when you're done with it, affix the new labels, reseal the envelope, and mail it back to the Library.

The College Library is expanding its book collection in rural health. If you have suggestions, questions, or require assistance, contact the Library at medlib@cpsbc.ca or 604 733-6671. ■

—Paula Osachoff
Librarian

BCCDC

Continued from page 89

the effect of this virus on our community will be limited. However, as of late February, community transmission is occurring in multiple locations globally including South Korea, Japan, Singapore, Iran, and Italy. This raises the probability of sustained community transmission in BC.

If sustained local transmission occurs, the focus of the intervention will shift. Testing for COVID-19 will decrease even as community cases increase, as we shift from containment to mitigation. People with mild symptoms consistent with COVID-19 (or with other respiratory illnesses), in whom knowledge of the infectious agent would not change management, will be asked to self-isolate without testing. Testing capacity will focus on severe cases and on sentinel surveillance, which will allow us to estimate the total disease burden and monitor trends in disease activity in our communities. In this scenario, clinicians will be asked to support patients by educating them on basic self-care measures at home when symptomatic; reinforcing messaging about hand hygiene, respiratory etiquette and the importance of self-isolation during illness to prevent transmission; and identifying patients experiencing severe symptoms or at risk of severe disease who will need more intensive management and support. Additional social distancing strategies, such as telecommuting or discouraging mass gatherings, will be recommended by public health only if the epidemiology of the disease suggests significant transmission in these settings. Once mitigation is the goal, it will remain essential that measures to prevent health care–associated transmission, including adherence to personal protective equipment guidelines, be maintained. Some nonessential services may need to be paused to meet demand and maintain continuity of care for urgent medical needs.

A novel disease such as COVID-19 is a challenge to our health care system, but also an opportunity to strengthen our relationships in service of patient needs. It remains essential to have a rational and measured response to COVID-19 while ensuring that uncertainty and fear do not lead to undue disruption and delay of care. On behalf of public health physicians in British Columbia, we thank you for your partnership. ■

—Alexis Crabtree, MD, MPH, PhD
Resident Physician, Public Health and Preventive Medicine, University of British Columbia

—Alexandra Choi, MD, MHSC, CCFP
Medical Health Officer, Fraser Health

—Althea Hayden, MDCM, MPH, FRCPC
Medical Health Officer, Vancouver Coastal Health

—Réka Gustafson, MD, CCFPC
Vice President Public Health and Wellness, Provincial Health Services Authority, Deputy Provincial Health Officer

—Bonnie Henry, MD, MPH, FRCPC
Provincial Health Officer

Information on COVID-19 from Doctors of BC, updated regularly:
www.doctorsofbc.ca/covid-19

Changing drug policies: What do we need to end this heartbreaking crisis?

Since the overdose crisis was declared a public health emergency in 2016, nearly 14 000 Canadians have died as a result. Due to the number of fatal overdoses, BC's life expectancy has fallen for the first time in modern history.

Facing this crisis, many organizations, such as Nurses and Nurse Practitioners of BC,[1] Moms Stop the Harm,[2] the Canadian Association of People Who Use Drugs,[3] and the City of Vancouver,[4] have called for a change in drug policies, including drug decriminalization and increased access to a safer supply of drugs. Nonetheless, both the federal and provincial government have been hesitant to fully commit to these ideas.

The concept of drug decriminalization is not new. Portugal decriminalized personal possession of all drugs in 2001. While having drugs for personal use is no longer a criminal offence, it remains an administrative violation. The money saved in the criminal justice system has freed up resources to be invested in addiction treatment, mental health, and social services. Within a decade of decriminalizing drugs in Portugal, continuation rates of drug use dropped by 15%. In addition, the rate of HIV, hepatitis, and drug-related deaths and crimes decreased. This shift from a criminal to public health approach to drug use has received praise from many international organizations, including the United Nations.

This article is the opinion of the Emergency and Public Safety 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.*

In terms of safe supply, Switzerland offers a good example. Like much of Europe, the country experienced a rapid rise in IV heroin use during the 1970s and 80s, which led to high rates of HIV transmission and drug-related deaths. Since the mid-1990s, Switzerland has offered heroin-assisted treatment (HAT). With over 20 years of data, it's clear that HAT has substantially improved the well-being of the participants, reduced continual use of illicit heroin, and decreased criminal activities. Locally, the BC Centre on Substance Use published an evidence-based document last year that highlights the benefits and rationale for safe supply, and a proposed model for implementation.[5]

I can think of a particular patient whose story reinforced my support for changing drug policies. Over the years, my team and I provided her with medical and psychosocial treatment for her opioid-use disorder while she worked diligently on her recovery. By the time she moved on to another clinic closer to her new home, she had obtained her diploma and was ready to start a new job to help youth struggling with addiction. I still remember the light in her eyes and the confidence in her smile when she told me about her graduation and the new job. Meanwhile, as I recalled the multiple overdoses she had in the past, a shivering thought came to mind: she could have died so many times. Sadly, not every patient of mine was as lucky as she was; many had died from overdoses and were never able to continue the journey of recovery.

I truly believe that decriminalization of people who use drugs and safe supply save lives. We need to change outdated drug policies so our patients struggling with addiction can stay alive and have an opportunity to access the treatment and support they need. By doing so, we are sending a clear message to society that drug addiction is a health issue, not a criminal issue, which in turn helps reduce stigma and encourages more individuals to access care or call 911 in case of an overdose without the fear of being incarcerated.

We are sending a clear message to society that drug addiction is a health issue, not a criminal issue.

As doctors in the province with the highest number of overdoses and deaths in Canada, we should engage in a broader discussion about these important issues. ■

—**Derek Chang, MD**

References

1. Nurses and Nurse Practitioners of BC and Harm Reduction Nurses Association. Nurses and Nurse Practitioners of British Columbia (NNPBC) and the Harm Reduction Nurses Association (HRNA) call for the decriminalization of people who use drugs in BC. August 2019. Accessed 27 February 2020. www.nnpbc.com/pdfs/media/press-releases/PR-HRNA-NNPBC-Statement.pdf.
2. Moms Stop the Harm. Key beliefs. Accessed 27 February 2020. www.momsstoptheharm.com/key-beliefs.
3. Canadian Association of People Who Use Drugs. Safe supply concept document. February 2019. Accessed 27 February 2020. https://vancouver.ca/files/cov/capud-safe-supply-concept-document.pdf.
4. City of Vancouver. Safe supply statement. July 2019. Accessed 27 February 2020. https://vancouver.ca/people-programs/safe-supply-statement.aspx.
5. BC Centre on Substance Use. Heroin compassion clubs: A cooperative model to reduce opioid overdose deaths and disrupt organized crime's role in fentanyl, money laundering and housing unaffordability. February 2019. Accessed 27 February 2020. www.bccsu.ca/wp-content/uploads/2019/02/Report-Heroin-Compassion-Clubs.pdf.

In search of collaboration between Indigenous traditional practice and Western medicine

An emergency physician's experience and a traditional practitioner's experience.

Kendall Ho, MD, Gerry Oleman

DR KENDALL HO: What if one day a patient asks you for therapy based on Indigenous traditional medicine? This happened to me 6 years ago when I was working in the emergency department. I saw an Indigenous patient after he had a car accident and I recommended a standard treatment plan. He politely declined and asked for Indigenous traditional medicine instead. I was unsure how to proceed as I knew very little about this approach. He thanked me and we parted company amicably. This began my journey to explore Indigenous traditional medicine and how it might be used in combination with Western medicine. Soon afterward I met Elder Gerry Oleman, who became my teacher and guide, opening my eyes to how traditional practitioners contribute to the BC medical system.

ELDER GERRY OLEMAN: In 1995 families with a loved one in hospital started to call me. When I reflect on these first calls, I think about how I had not been formally identified as someone to call in the Indigenous world when there is a medical crisis. I was called because I was known for practising Indigenous ceremony, meaning I was taught and mentored by Elders in Indigenous ways of helping those in need. Today when I am called to the hospital, I connect with the family first so I can learn what is going on with the patient. Once I have the information, I share with the family and patient what I will be doing and carry on only after obtaining their approval. Since I am working in a hospital setting, I understand that the patient is in the hands of competent medical professionals and that we should not interfere with each other's practices. I see my involvement as providing what is missing for the patient: attention for the soul/spirit of the patient. With my words, songs, prayers, and spiritual tools I am helping to strengthen the spirit of the individual. If I accomplish this, the patient can become an active participant in the healing process. I believe that what Indigenous practitioners provide in this moment of damage to physical health can improve the mental and spiritual health of the patient. I also believe practitioners have a responsibility to assist family and friends who are present so that they can support the patient and medical staff in the healing process.

When I look at my involvement and journey working with patients, families, and health care professionals in the medical system, I see the need for all involved to understand each

> **"We have just begun the journey and look forward to expanding this work of integrating traditional and Western medical systems to best support Indigenous patients.**

Kendall Ho, MD, Professor, Department of Emergency Medicine, University of British Columbia.

other's roles and responsibilities. Working with patients and families early on, I came to appreciate the rhythm of the hospital and would plan my work around that rhythm. As a result, I have never had conflict with the system. I do not have formal recognition when I am called to the hospital, yet the Indigenous practices I offer patients are not disallowed. I have heard of Indigenous practitioners having difficulties carrying out their work of assisting patients. This may very well be because of ignorance or racism on the part of the health care staff. It has been my experience that those in the medical system will respect an Indigenous practitioner when they understand that the two systems can support one another and benefit the patient. I believe that although there are differences, when we work together and do not interfere with each other these differences can be worked out. After all, Indigenous practitioners are involved in the medical system at the request of families and patients. I am grateful to the Canadian medical system for all the services it has provided to me and my family. I am also extremely grateful to the traditional practitioners who have provided comfort, hope, and success for members of my family and for myself personally.

Gerry Oleman, Elder and Traditional Practitioner, the St'at'imc Nation.

DR KENDALL HO: As an emergency physician, my journey with Elder Gerry Oleman and other traditional practitioners has helped me better understand the context of Indigenous patients, their caregivers, and their communities regarding a holistic approach to health and wellness, and the potential anxiety some patients may experience when seeking Western medical care. This journey raises my awareness of the need for cultural safety and positively changes my practice when I interact with Indigenous patients. My journey also challenges me to be more aware of and seek understanding from all patients I encounter and treat.

As executive director of the interCultural Online Health Network (iCON), I would like to thank the many collaborators and supporters who have been part of this journey so far to incorporate traditional healing into the BC health care system. I would like to thank the numerous Indigenous Elders and their communities and all of the BC health authorities, particularly the First Nations Health Authority, Vancouver Coastal Health, and Island Health. I would also like to thank the BC Ministry of Health for providing support through the Patients as Partners Initiative. We have just begun the journey and look forward to expanding this work of integrating traditional and Western medical systems to best support Indigenous patients. If you feel inspired by our stories, I invite you to join us on our journey to learn more and to collaborate with us. ■

Acknowledgments

We would like to acknowledge that the activities discussed in this issue of the *BCMJ* took place on the traditional unceded homelands of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations, and the land of the W̱SÁNEĆ (Pauquachin, Tsartlip, Tsawout, Tseycum) peoples.

Antonia Hyman, MSc, Elizabeth Stacy, MA, Kaitlin Atkinson, MPaH, Helen Novak Lauscher, PhD, Jon Rabeneck, Gerry Oleman, Penny Cooper, MALT, BScN, RN, Wendy Young, PhD, Carol Kellman, BScN, RN, Kendall Ho, MD, FRCPC

Digital storytelling and dialogue to support culturally safe health care for Indigenous patients in British Columbia

The integration of Indigenous healing practices in the province's health care system is being facilitated by a video that features traditional practitioners and Western medical professionals.

Ms Hyman was a project coordinator in Digital Emergency Medicine at the University of British Columbia when this article was written. Ms Stacy was a research coordinator in Digital Emergency Medicine in the eHealth Strategy Office at UBC when this article was written. Ms Atkinson was a researcher in Digital Emergency Medicine at UBC when this article was written. Dr Novak Lauscher is associate lead, research, in Digital Emergency Medicine at UBC. Mr Rabeneck is the Coast Salish community engagement coordinator with the First Nations Health Authority. Elder Oleman is a member of the St'at'imc Nation and has been involved as a change agent for First Nations communities and agencies. Ms Cooper is interim director of Aboriginal Health at Island Health. Dr Young is a research facilitator and knowledge translator with Island Health. Ms Kellman is an Aboriginal nurse practice leader at Providence Health Care. Dr Ho is a practising emergency medicine physician at Vancouver General Hospital. He is also a professor in the Department of Emergency Medicine at UBC and lead, Digital Emergency Medicine.

This article has been peer reviewed.

ABSTRACT: The interCultural Online Health Network (iCON) at the University of British Columbia has been collaborating since 2010 with health authorities and Indigenous communities across the province to support the integration of traditional medicine practices into Western primary care and acute care settings. This is being done to fulfill recommendations contained in health policy frameworks and strategic documents, including the Truth and Reconciliation Commission report, the United Nations Declaration of the Rights of Indigenous Peoples, and the BC Declaration on Commitment to Cultural Safety and Humility in Health Services. With the help of an advisory committee, a video and a discussion guide were produced in 2016. The video features the stories, experiences, and insights of individuals who have used traditional medicine in different health care settings. A workshop was organized to share the video and guide with patients and communities. This event focused on identifying gaps and barriers within regions and the wider system and on proposing actions to enable change. Participant recommendations were grouped according to whether the actions proposed could be taken at the individual, advocacy, community, or health care system level. The iCON team continues to cohost discussions designed to share learnings and engage communities, administrators, decision-makers, and policymakers in transforming the health system to better serve all British Columbians. The team welcomes feedback about experiences with traditional healing practices and efforts made to improve access to culturally safe health care for Indigenous patients in BC.

In 2010 the interCultural Online Health Network (iCON) at the University of British Columbia set out to explore problems faced by Indigenous peoples in British Columbia seeking health and wellness. Since then, iCON has been collaborating with health authorities and Indigenous communities across the province to support the integration of traditional medicine practices into Western primary care and acute care settings.

Providing culturally safe care for all Indigenous patients has been found to include:

- Ensuring all health care employees undertake cultural safety training.
- Fostering an understanding of Indigenous perspectives on health and wellness.
- Allocating time to build connections, relationships, and trust in the community.
- Supporting the integration of traditional practices through policy.

Context and background

The colonization of Indigenous peoples in Canada has adversely affected how the current Canadian health care system responds to the needs of Indigenous patients. Structural barriers, power imbalances, and the perseverance of stereotypes and racist attitudes all play a part.[1,2] One outcome of colonization is a lack of emphasis on traditional medicine and practices as important components of wellness for Indigenous peoples. Research and an environmental scan conducted by the First Nations Health Authority (FNHA) affirms the continued value of traditional medicine and practices within Indigenous communities.[1] Health policy frameworks and strategic documents, including the Truth and Reconciliation Commission report and the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP), highlight the need for improved services and support for Indigenous patients.[2-5] Specifically, UNDRIP article 24.1 states:

> Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.[5]

In November 2019 British Columbia was the first province to legally implement UNDRIP. Bringing BC laws in line with UNDRIP is part of a major shift in provincial and local commitments to improve health access and outcomes for Indigenous patients. The Declaration of Commitment on Cultural Safety and Humility in Health Services was signed by the BC Ministry of Health and all BC's health authorities in 2015[6] and by Doctors of BC in 2019.[7,8] The declaration commits health care professionals and organizations to culturally safe and appropriate practices and a process of mutual trust and respect when delivering services to Indigenous peoples. Specific health authority policies[9-14] and programs such as the San'yas Indigenous Cultural Safety Training Program[15] have been developed to support health care professionals. Nevertheless, medical trainees in Canada still receive limited education on the impacts of colonization and racism and little exposure to Indigenous traditional practices. This means that many newly trained health care providers are unable to provide culturally safe care.[16,17]

FIGURE. **The video and discussion guide,** *A Coming Together of Health Systems,* **features traditional practitioners, Elders, and Western health care professionals. Elder Gerry Oleman is pictured.**

Supporting cultural safety

iCON[18] began developing educational tools to support cultural safety[19,20] in 2015. As part of a community-based initiative operated by Digital Emergency Medicine at UBC,[21] iCON explored how to partner with Indigenous community members to address specific health priorities and develop culturally relevant health resources. iCON then worked with Vancouver Coastal Health (VCH) to create *A Coming Together of Health Systems*, a video[22] featuring Indigenous traditional healers **[Figure]** and a discussion guide.[23] The aims of the video and guide were to:

- Increase understanding of the role of traditional healing and the work of traditional practitioners.
- Encourage the integration of traditional healing into the care of Indigenous patients.
- Support positive health care experiences through a culturally safe care framework.

Throughout the development of the video and accompanying discussion guide, feedback was sought from an advisory committee that had been formed in 2012. This committee was originally a tripartite collaboration between iCON, the VCH Aboriginal Health Strategic Initiative, and the former UBC Institute for Aboriginal Health. Members included traditional practitioners, Elders, and the project team.

With the committee's help, stories and insights into traditional medicine were featured in the video. Traditional practices were described along with the experiences of individuals who have used traditional medicine in hospital settings. Key messages and learning objectives were summarized in the guide and included with reflection questions and additional resources.

The video and guide were piloted with health care professionals at Vancouver General Hospital and St. Paul's Hospital to validate them, ensuring that the content was accessible and deepened understanding of traditional healing practices that patients might request in hospital settings.

The video and guide have now been disseminated through education sessions with health authorities, integrated into VCH cultural safety training, and presented at various conferences, including the 2016 Fourth Global Symposium on Health Systems Research and the BC Ministry of Health summit in 2017.[22-24] The video

and guide are also now integrated into the UBC medical school undergraduate curriculum.

A Coming Together of Health Systems is not intended to be a definitive resource concerning traditional practitioners and healing services but a starting point for dialogue. Before medical professionals can be comfortable and confident providing culturally safe care, they must first recognize the value of offering dual services (traditional Indigenous and Western) in serving their patients, and must gain a more nuanced view of the nature of traditional healing practices. Watching the video and sharing experiences with a diverse group of stakeholders can produce attitude shifts and practice changes and have rich cultural impacts for both Indigenous and non-Indigenous British Columbians.

Community dialogue

To understand how the health care system can best integrate traditional healing into everyday practice, a community dialogue workshop was cohosted by iCON, VCH, Island Health, and FNHA on 15 March 2017. Elders, traditional practitioners, nurses, physicians, students, and Ministry of Health representatives were invited to Tsawout, located on the homelands of the W̱SÁNEĆ peoples on the Saanich Peninsula, and asked to identify gaps and barriers in the system and to produce a list of recommendations.

The workshop began with more than 100 participants viewing the video. A storytelling session followed, with Elders and traditional practitioners sharing their experiences of seeking and/or delivering traditional wellness and healing. The candid and personal accounts created a sense of community that carried on throughout the workshop.

Participants were divided into small groups for breakout sessions. Each group included a mix of health care professionals and community members to ensure a range of perspectives, expertise, and experiences were represented. In these sessions, participants were invited to share their views on ways to provide better access to traditional medicine within the BC health care system and how to harmonize Indigenous and Western approaches. Guiding questions were provided:

- In what ways can access to traditional practitioners be improved in your work setting at the clinical/practice level?
- How should we start thinking about shifting and changing health care system settings to better incorporate traditional medicine?
- What type of policy needs to be in place to facilitate and enable the changes discussed?

Before medical professionals can be comfortable and confident providing culturally safe care, they must first recognize the value of offering dual services … and gain a more nuanced view of the nature of traditional healing practices.

Perspectives and proposed actions

The post-workshop evaluation surveys that were completed by 59 participants showed how perspectives were changed: 93% felt the workshop helped them better understand traditional healing and the role of traditional practitioners; 89% agreed they would use the information from the workshop to better facilitate access to traditional practitioners; and 81% agreed they would make a change to improve the BC health care system to better incorporate traditional medicine.

Participant recommendations gathered from the breakout sessions were analyzed and grouped according to whether the actions proposed could be taken at the individual, advocacy, community, or health care system level.

Individual actions

All health care employees, including administrative staff, should engage in cultural safety training as part of an ongoing learning journey that helps individuals to:

- Practise humility and self-reflection in words, actions, and work activities.
- Integrate learning into their work.
- Increase knowledge of resources already in place at hospitals (e.g., how to access traditional practitioners).
- Continue the dialogue and share with colleagues (e.g., start conversations at staff meetings).
- Respond to the patient's need in the moment (e.g., ask "What do you need/want?" or "Are there any resources outside the ones we are providing that might help you?").

Advocacy actions

Advocacy for traditional healers and practitioners should include actions that encourage individuals, community-based organizations, and policymakers to:

- Respect the use of Indigenous language and worldviews as integral to the healing process.
- Promote a better understanding of the value of culturally safe care and the different perspectives Indigenous patients may have on health and wellness.
- Shift the definition and understanding of "health" to incorporate mental and spiritual health.
- Address misconceptions and mistrust through education about traditional healing and its value.
- Recognize and embrace the power of storytelling to create a space for shared understanding and self-reflection and to build community resiliency.
- Avoid tokenism.

Community actions

Community-based organizations should engage with others to:

- Include more policymakers in future workshops and dialogue.
- Build experiential learning and training opportunities for health care professionals, trainees, and medical students.
- Increase involvement of community advocates, patient voices, and Aboriginal liaison nurses.
- Codevelop protocols led by traditional practitioners in partnership with health authorities.

- Develop a directory for contacting traditional practitioners.
- Use a Plan-Do-Study-Act model for quality improvement to increase access to traditional practitioners in work settings.
- Allocate time to build connections, develop relationships, and increase trust with traditional practitioners and community leaders.
- Create space for authentic discussions and meaningful relationships.

Health care system actions

Policymakers should engage with others to:

- Acknowledge the spiritual side of wellbeing in policy.
- Incorporate healing rooms into the health system.
- Make cultural safety training mandatory (e.g., San'yas Indigenous Cultural Safety Training).
- Navigate and translate policy at the local level.
- Incorporate appropriate language in new policy mandates (e.g., avoid inappropriate terms such as "our Indigenous people," which implies ownership).
- Develop protocols and policy for accessing traditional practitioners.
- Adapt funding models to incorporate traditional practitioners, Aboriginal liaison nurses, and Elders-in-residence.

Feedback welcomed

iCON, FNHA, and the province's health authority partners remain committed to collaborative, inclusive dialogue that helps participants reach a greater understanding of barriers, challenges, and experiences in accessing culturally safe care.

The iCON team continues to cohost discussions that provide an opportunity for Indigenous peoples to share insights and guidance on forging a pathway to culturally safe care and that engages administrators, decision-makers, and policymakers in transforming the health care system to better serve all British Columbians.

We welcome feedback from readers about their own experiences with traditional healing practices and any efforts made to improve access to culturally safe health care for Indigenous patients in BC. ■

Competing interests

UBC Digital Emergency Medicine has received funding from the BC Ministry of Health to organize these events.

Acknowledgments

We would like to acknowledge that the activities discussed in this issue of the *BCMJ* took place on the traditional unceded homelands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) First Nations, and on the land of the W̱SÁNEĆ (Pauquachin, Tsartlip, Tsawout, Tseycum) peoples. We would like to say a special thank you to all of the participants, event organizers, and panel speakers at the inaugural 2017 workshop for their invaluable contributions. Thank you also to Allison Boothe and Susan Powell for their invaluable support. Finally, thank you to the BC Ministry of Health Patients as Partners Initiative for making this work possible.

References

1. First Nations Health Authority. Traditional wellness strategic framework. 2014. Accessed 11 February 2020. www.fnha.ca/WellnessSite/WellnessDocuments/FNHA_TraditionalWellnessStrategicFramework.pdf#search=Traditional Wellness Strategic Framework.
2. Truth and Reconciliation Commission of Canada. Calls to action. 2015. Accessed 11 February 2020. http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf.
3. Ministry of Health. The transformative change accord: First Nations health plan. 2006. Accessed 11 February 2020. www.health.gov.bc.ca/library/publications/year/2006/first_nations_health_implementation_plan.pdf.
4. First Nations Health Council. British Columbia First Nations perspectives on a new health governance arrangement: Consensus paper. 2011. Accessed 11 February 2020. www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf.
5. United Nations. United Nations declaration on the rights of Indigenous peoples. 2007. Accessed 11 February 2020. www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.
6. First Nations Health Authority. Declaration of commitment on cultural safety and humility in health services. 2015. Accessed 11 February 2020. www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf.
7. Doctors of BC. Supporting cultural safety for First Nations. 2018. Accessed 11 February 2020. www.doctorsofbc.ca/news/supporting-cultural-safety-first-nations.
8. BC Medical Journal. A commitment to cultural safety and humility. BCMJ 2019;61:249.
9. Interior Health Authority. Healthier you. Summer 2016. Accessed 11 February 2020. www.interiorhealth.ca/AboutUs/MediaCentre/PublicationsNewsletters/Documents/Healthier You - Summer 2016.pdf.
10. Island Health Authority. Learn about health: Indigenous health. Accessed 11 February 2020. www.islandhealth.ca/learn-about-health/aboriginal-health.
11. Fraser Health Authority. Aboriginal health. Accessed 11 February 2020. www.fraserhealth.ca/health-topics-a-to-z/aboriginal-health#.XaddHuhKi70.
12. Northern Health Authority. Cultural safety: Supporting increased cultural competency and safety throughout Northern Health. Accessed 11 February 2020. www.indigenoushealthnh.ca/initiatives/cultural-safety.
13. Provincial Health Services Authority. Indigenous health. Accessed 11 February 2020. www.phsa.ca/our-services/programs-services/indigenous-health.
14. First Nations Health Authority. FNHA overview. Accessed 11 February 2020. www.fnha.ca/about/fnha-overview.
15. Provincial Health Services Authority. San'yas Indigenous cultural safety training. 2018. Accessed 11 February 2020. www.sanyas.ca/about-us.
16. DeCoteau MA, Lavallee B. Lessons learned and pathways forward Indigenous medical workforce development in Canada since 2004. Focus Health Prof Educ 2011;13.
17. Baker AC, Giles AR. Cultural safety: A framework for interactions between Aboriginal patients and Canadian family medicine practitioners. Int J Indig Health 2013;9:15.
18. interCultural Online Health Network (iCON). Welcome to the interCultural Online Health Network. Accessed 11 February 2020. https://about.iconproject.org.
19. Zibrik L, Khan S, Bangar N, et al. Patient and community centered eHealth: Exploring eHealth barriers and facilitators for chronic disease self-management within British Columbia's immigrant Chinese and Punjabi seniors. Health Policy Technol 2015;4:348-356.
20. Zibrik L, Khan S, Novak Lauscher H, et al. iCON: Supporting Chinese and South Asian BC citizens for optimal self-management. BCMJ 2015;57:244-245.
21. University of British Columbia. Digital Emergency Medicine. Department of Emergency Medicine. Accessed 11 February 2020. https://digem.med.ubc.ca.
22. interCultural Online Health Network (iCON). A coming together of health systems: Traditional practitioners in acute care settings. Video. Vancouver: iCON; 2016. Accessed 12 February 2020. https://indigenous.iconproject.org.
23. interCultural Online Health Network (iCON). A coming together of health systems: First Nations traditional practitioners in acute care settings discussion guide. Vancouver: iCON; 2016. Accessed 12 February 2020. https://indigenous.iconproject.org.
24. Stacy E, Ho K. Integrating cultural humility into health care using a video on Indigenous health. Presented at BC Patient Safety and Quality Council Quality Forum 2018, Vancouver, 22 Feburary 2018.

J. Connell, BSc, MPH, J. Kur, MD, FRCPC, J.H. Gurmin, LPhil, PhD

Assessing the impact of a nursing model of care on rheumatology practice patterns and patient satisfaction in British Columbia

Study results from three clinics indicate a significant increase in outpatient encounters and high levels of patient satisfaction after implementation of a rheumatology multidisciplinary care assessment billing code.

ABSTRACT

Background: Timely access to care and control of disease activity in inflammatory arthritis is crucial to maintain patient quality of life and prevent joint damage and loss of function. In 2010 BC faced a shortage of rheumatologists caused in part by disparities between rheumatology and other subspecialties. To address the resulting service shortages, rheumatologists in BC explored multidisciplinary patient care approaches, including a new fee-for-service code that allows nurses to provide education and counseling to patients concerning medication, diet, and exercise. The nursing model of outpatient rheumatology care that resulted has changed the practice patterns of BC rheumatologists. A study was proposed to explore how patient access to rheumatology care has changed since the implementation of the Multidisciplinary Conference billing code G31060 (as of 1 April 2020 called the Multidisciplinary Care Assessment billing code) and how acceptable this model of care is to patients.

Methods: In 2018 a review of electronic medical records was conducted in three rheumatology clinics in British Columbia to measure changes in the number of outpatient encounters before and after the implementation of a nursing model of care. Data from the records were used to generate descriptive statistics. RCPSC-certified rheumatologists in BC were asked to respond to a survey about practice patterns. Patients were asked to respond to a survey about six aspects of care: general satisfaction, giving of information, empathy with the patient, technical quality and competence, attitude toward the patient, and access and continuity. A literature review was completed to identify studies of physician-led care in similar patient populations.

Results: The mean number of weekly outpatient encounters per rheumatologist for all inflammatory diseases was 17.4 patients per week in 2009 and 30.4 patients per week in 2016, an increase of 74.7% (13 patients per rheumatologist per week). When encounters were considered by diagnosis, there was a mean increase of 84.0% for diffuse diseases of connective tissue (3.8 patients per rheumatologist per week), 56.9% for rheumatoid arthritis (4.6 patients), 118.3% for ankylosing spondylitis (2.4 patients), and 75.3% for psoriatic arthritis (2.2 patients). Survey results for patient satisfaction show the care was highly acceptable, with a mean overall patient score of 4.35 out of 5.00. Survey results for rheumatologist practice patterns show an increase in the use of nursing support, with only 23% having access to nursing support in 2010 and 71% having access after implementation of the billing code.

Conclusions: More outpatient encounters for all disease types were seen at all three participating rheumatology clinics after implementation of the billing code. Rheumatologists received increased remuneration and had time to see more patients while nurses assisted with patient assessments and educated patients about medications, diet, and exercise. Patient satisfaction scores for six aspects of care were all higher than 4.00 out of 5.00.

Mr Connell is an independent health economics and outcomes research consultant. Dr Kur is president of the BC Society of Rheumatologists and a clinical associate professor in the Division of Rheumatology at the University of British Columbia. Dr Gurmin is a research consultant affiliated with Artus Health Centre.

This article has been peer reviewed.

Background

Rheumatologists are internal medicine subspecialists who care for patients with systemic autoimmune diseases such as rheumatoid arthritis, lupus, vasculitis, and inflammatory diseases of the back. In addition, rheumatologists care for patients with complicated musculoskeletal problems such as advanced osteoarthritis, injuries, and tendinopathies. Public Health Agency of Canada data indicate that the burden of rheumatic diseases is increasing.[1]

In BC rheumatologic care is primarily delivered in an outpatient private practice clinic setting. The patients seen in a rheumatologist's clinic suffer from some of the most complicated diseases in medicine. Disorders in rheumatology strike multiple organ systems, including the joints, heart, skin, muscle, lungs, and kidneys. The rheumatologist is often a coordinator of care for patients with complicated disease who require a holistic, multidisciplinary approach to their multiorgan pathology.

Timely access to care and control of disease activity in inflammatory arthritis is crucial to prevent joint damage and loss of function and to maintain quality of life. Joint damage can occur within 3 months of disease and lead to disability. Research has shown that intervention with disease-modifying antirheumatic drug (DMARD) therapy will help patients with inflammatory arthritis achieve disease remission, improve physical function, and prevent long-term disability. Previous studies in BC have shown that only 39% of the early incident rheumatoid arthritis population and 45% of the prevalent late rheumatoid arthritis population were receiving DMARD therapy, suggesting the existence of large service gaps.[2,3]

In 2010 BC was faced with a shortage of rheumatologists. Recruitment and retention pressures, caused in part by disparities between rheumatology and other subspecialties, had resulted in poor access to care for BC residents with rheumatic diseases. At that time, there were only 32 full-time equivalent (FTE) rheumatologists in the province, or one rheumatologist for every 140 000 residents.[4] Guidelines recommend a rheumatologist-to-patient ratio of 1:70 000, which meant that the BC population was underserviced by approximately 32 FTEs. In addition, 33% of rheumatologists reported that wait times for nonurgent consults were longer than 4 months, suggesting that the shortage of rheumatologists was having an impact on patient outcomes.[4]

To address these service shortages, rheumatologists in BC explored patient care approaches through the Specialist Services Committee (SSC). This eventually led to the introduction of a Multidisciplinary Conference billing code G31060 (as of 1 April 2020 called the Multidisciplinary Care Assessment billing code) that allowed for nursing support in outpatient rheumatology care.

The new billing code allows patients with complex inflammatory disease to receive personalized counseling and education from rheumatology nurses, including education about medications, diet, immunization, and exercise, training in self-injection of rheumatologic agents, and counseling for DMARD therapy.[5] This support from nurses in the management of patients frees up more physician time and allows for more care to be delivered in fewer encounters, thus reducing the number of visits to other health care professionals.

The new billing code allows patients with complex inflammatory disease to receive personalized counseling and education from rheumatology nurses.

Since the billing code was introduced, there has been a dramatic shift in the delivery of rheumatology care for outpatients in BC. A specialty nursing group has been established, BC Rheumatology Nurses, and rheumatologists throughout the province have engaged nurses in their clinics part-time and full-time.

The introduction of multidisciplinary teams that include rheumatology nurses has changed the practice patterns of BC rheumatologists and has potentially changed patient access to care. Because access to care is a quality indicator, the changes made have the potential to alter the quality or acceptability of care for patients.[6] A study was proposed to explore how patient access (the number of rheumatology patients seen in a period of time by an individual rheumatologist) has changed since the implementation of the billing code and how acceptable this model of care is to patients.

Methods

An electronic medical record (EMR) review was conducted in the summer of 2018 to measure changes in the number of patient visits in three urban rheumatology clinics in Vancouver and Victoria.

Each rheumatology clinic was run by a single specialist, was using the same EMR system, and was operating both before and after implementation of the billing code in 2010. The total number of distinct patients seen per year was measured for 2009 and for 2016 to allow for a 6-year period of adjustment after the billing code was implemented. Each patient was counted only once in a year, regardless of the number of visits to the clinic, to determine if more individual patients were being seen with the change in the model of care as opposed to the same patient being seen more often. The number of days the clinic's rheumatologist worked that year were taken into account, and the encounters were stratified by inflammatory disease type (connective tissue diseases, rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis).

Additional data were obtained from 2010 and 2018 surveys by the BC Society of Rheumatologists. Each online, self-administered survey consisted of questions on demographics and practice patterns. The surveys were sent out to all RCPSC-certified rheumatologists in BC. The response rate for 2010 was 98% (n = 45) and for 2018 was 91% (n = 77). These data were supplemented with billing information provided by the BC Medical Services Plan (MSP), the sole insurer for rheumatology services in the region.

Data on patient satisfaction were collected using the Leeds Satisfaction Questionnaire (LSQ), a validated and reliable tool for assessing care in rheumatology outpatient clinics.[7]

Patients were asked to consider 45 statements and use a Likert scale to rate six aspects of their rheumatology care: general satisfaction, giving of information, empathy with the patient, technical quality and competence, attitude toward the patient, and access and continuity. The LSQ was administered in English to outpatients with inflammatory disease 19 years and older who were attending a follow-up appointment and were able to complete the survey on their own. The questionnaire was completed in the waiting room before the appointment to ensure the responses were not biased by the most recent interaction or by acquiescence bias resulting from the presence of the rheumatologist.

The completed questionnaires were sealed in envelopes and patients were assured they would remain anonymous and their responses would not be viewed by the treating rheumatologist. Questionnaires were collected in two of the three rheumatology clinics studied. Means from the responses were pooled and compared with values from studies identified in a literature review as having similar patient populations but more traditional physician-led service delivery methods.[8,9]

Descriptive statistics were calculated during data analysis. As this was an exploratory health services study, the patient access measure was not powered to allow for statistical comparisons between physicians. The study was done as part of an evaluation of labor market adjustment (LMA) fees. Funding for the evaluation was provided by the Specialist Services Committee, a joint collaborative committee of Doctors of BC and the BC Ministry of Health. Ethics approval for the study was obtained from the University of British Columbia Behavioural Research Ethics Board.

Results

In 2009, before implementation of the billing code for rheumatology, 1493 patient encounters occurred over 439 working days. In 2016, after implementation, 2761 patient encounters occurred over 463 working days. The mean number of weekly outpatient encounters per rheumatologist for all inflammatory diseases was 17.4 patients per week in 2009 and 30.4 patients per week in 2016, an increase of 74.7% (13 patients per rheumatologist per week) **[Figure 1]**.

The mean overall satisfaction score was 4.35 out of 5.00.

When encounters were considered by diagnosis, there was a mean increase of 84.0% for diffuse diseases of connective tissue (3.8 patients per rheumatologist per week), 56.9% for rheumatoid arthritis (4.6 patients), 118.3% for ankylosing spondylitis (2.4 patients), and 75.3% for psoriatic arthritis (2.2 patients) **[Figure 2]**.

The Leeds Satisfaction Questionnaire was completed by 92 patients at two of the three rheumatology clinics studied. The mean overall satisfaction score was 4.35 out of 5.00 and all aspects of care received ratings higher than 4.00. When these results were compared with results from studies in Alberta and Norway, the scores in British Columbia were found to be equal or significantly higher **[Table]**.

Only 23% of rheumatologists in 2010 had access to nursing support as part of their practice, but that number increased to 71% in 2018, after implementation of the billing code **[Figure 3]**. From 2011 to 2018, the use of the code across BC increased by 234%. Billings per rheumatologist went from 140 in the 2011/12 fiscal year (the first year after code G31060 was implemented) to 467 billings in the 2017/18 fiscal year (written communication with Raaj Tiagi, senior health economist, Doctors of BC, 16 January 2019) **[Figure 4]**. As of 2018, 22 FTE nurses were employed in rheumatology community outpatient clinics in BC, compared with only one nurse in 2010.

Conclusions

The number of outpatient encounters is a vital metric when determining accessibility of care for rheumatology patients. Increases in patient visits were seen for all three rheumatology clinics studied and for all disease types after implementation of the billing code. This suggests that rheumatologists can care for more

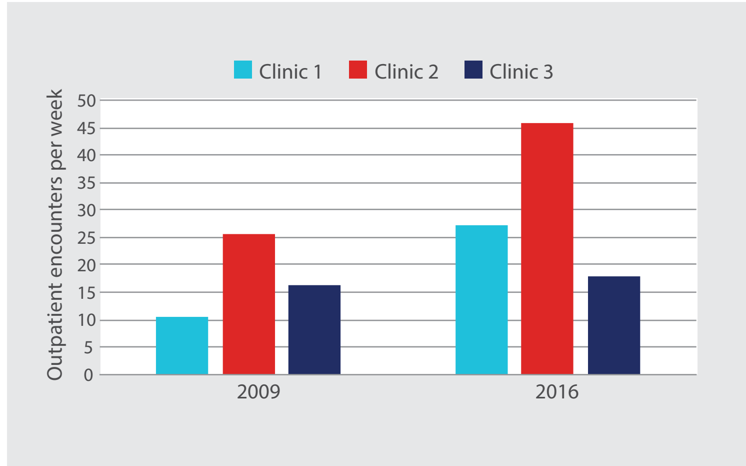


FIGURE 1. Number of weekly outpatient encounters by rheumatologist at three BC clinics in 2009 (before implementation of billing code G31060) and in 2016 (after implementation).

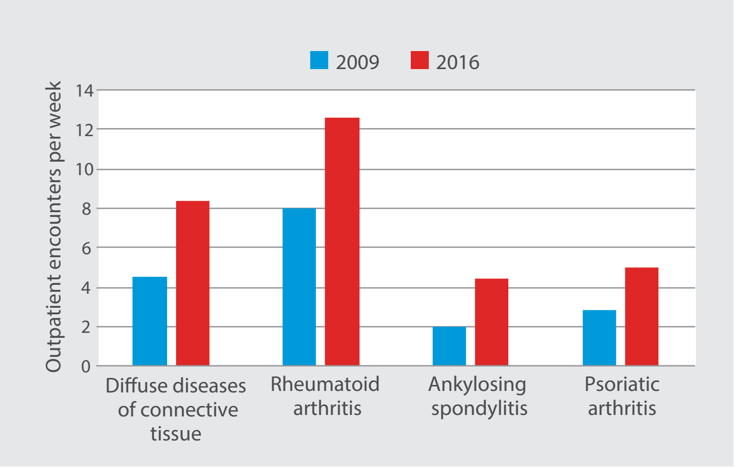


FIGURE 2. Number of weekly outpatient encounters by diagnosis at three BC clinics in 2009 (before implementation of billing code G31060) and in 2016 (after implementation).

patients with nursing support than they can without this support.

Rheumatology is a time-intensive specialty with patients having complex histories, requiring detailed physical examinations, and needing information about the expanding field of biologic treatments. The observed increase in patient access is substantial given the complexity of the patients involved. Also, it is important to note that the increase in access at the three rheumatology clinics studied means that joint damage and function loss in those patients with inflammatory conditions was probably prevented.

Advantages of the nursing model

Studies have shown that nurse-led care in rheumatology is acceptable, safe, and equally effective as physician-led care.[10] A systematic review by Garner and colleagues demonstrates conflicting evidence about the cost-effectiveness of implementing nurse-led care, but most studies suggest that it either costs the same or less than other models of care.

When assessing patient satisfaction with this model, we compared our results with those from two recent studies with similar patient populations, namely traditional physician-led health service delivery methods in Alberta[8] and Norway.[9] The equal and significantly higher scores found in our study suggest greater satisfaction with multidisciplinary care in BC as compared with physician-led care in Alberta and Norway. Any negative impact caused by implementing a nursing model of rheumatology care has not been significant, with all aspects of care scoring more than 4.00 out of 5.00.

Results from the 2018 BC Society of Rheumatologists survey suggest multiple advantages to having additional nursing support in outpatient rheumatology practices. Rheumatologists benefit from increased remuneration and from having time to see more patients while nurses assist with patient assessments and educate patients about medications, diet, and other aspects of care.

Recommendations from the European League against Rheumatism (EULAR) state that patients should have access to nursing support for education purposes. The league also concluded that statistically significant higher levels of knowledge were found in patients with access to nursing support compared with those seen only by rheumatologists.[11,12] In addition, the recommendations state that the participation of nurses can help control disease activity and improve patient-preferred outcomes.[6]

TABLE. Results from Leeds Satisfaction Questionnaire (LSQ) completed in British Columbia, Alberta, and Norway by patients at rheumatology clinics using a multidisciplinary care model.

LSQ aspects of care	British Columbia, 2018 (95% CI)	Alberta, 2017[9] (95% CI)	Norway, 2013[10] (95% CI)
General satisfaction	4.26 (4.10, 4.41)	4.25 (4.10, 4.40)	4.06 (3.82, 4.30)
Giving of information	4.34 (4.23, 4.45)	4.2 (4.06, 4.34)	3.81 (3.29, 4.03)
Empathy with the patient	4.28 (4.17, 4.39)	4.02 (3.85, 4.19)	3.83 (3.62, 4.03)
Technical quality and competence	4.59 (4.49, 4.69)	4.53 (4.40, 4.66)	4.49 (4.31, 4.68)
Attitude toward the patient	4.42 (4.32, 4.53)	4.46 (4.30, 4.62)	4.05 (3.83, 4.27)
Access and continuity	4.21 (4.09, 4.33)	N/A*	3.40 (3.18, 3.62)
Overall satisfaction	4.35 (4.25, 4.45)	4.30 (4.17, 4.43)	3.95 (3.80, 4.11)
Ophthalmology	3 (1–7)	55	310
Plastic surgery	5 (3–8)	75	189
Radiology	3 (1–9)	56	84
Immunology	1 (0–4)	50	70

*Results could not be compared because researchers altered the questions for access and continuity.

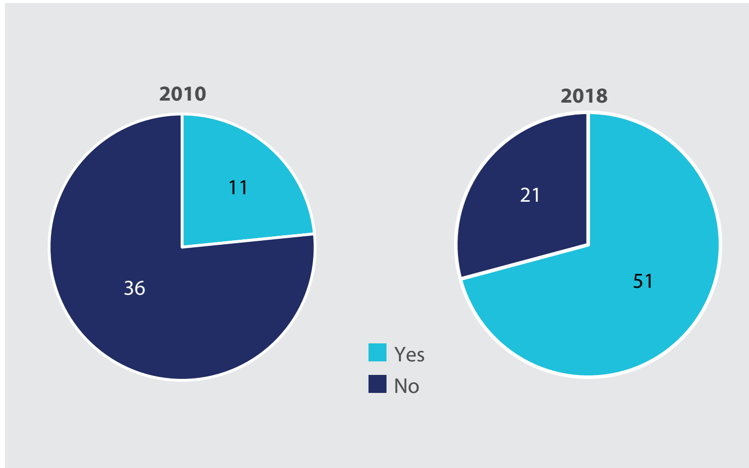


FIGURE 3. BC rheumatologists with access to nursing support for care of outpatients in 2010 (before implementation of billing code G31060) and in 2018 (after implementation).

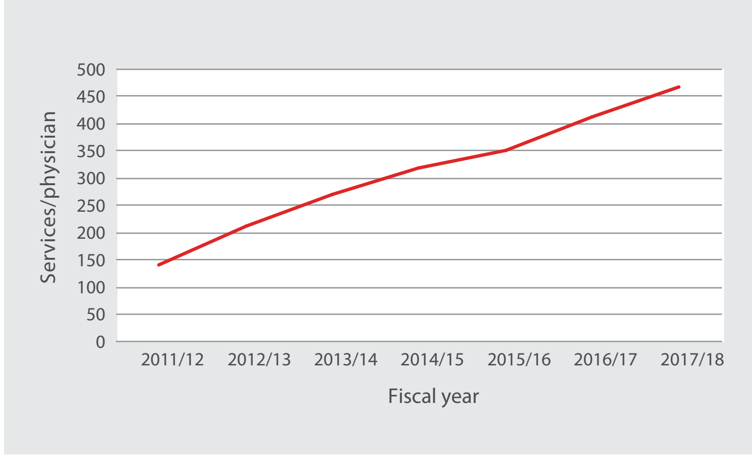


FIGURE 4. Use of code G31060 billings per rheumatologist by fiscal year, 2011–2018.

Study limitations

The results of our study have limited generalizability to rural and remote communities as the three participating clinics were all in urban centres. In addition, demographic shifts and other changes in the BC health system that were not measured may have had an impact on the change in patient visits over time. Regarding results from the Leeds Satisfaction Questionnaire, information was not collected on demographics or disease progression, so confounding variables could not be accurately analyzed to determine their effect on acceptability of care. Regarding the studies used for comparing patient satisfaction, there were two issues. First, the Norway study had a different time frame as compared to the Alberta and British Columbia studies. Second, a control clinic with rheumatologist-only care could not be found in BC because all clinics approached to participate were already using nurses in some capacity, and a control clinic serving patients with noninflammatory disease would be inappropriate since patient satisfaction is known to vary by disease type. In future, comparisons might be made in other provinces where nursing care is not common in rheumatology clinics.

As of 2018, 22 FTE nurses were employed in rheumatology community outpatient clinics in BC, compared with only one nurse in 2010.

Summary

Implementation of the rheumatology billing code G31060 in BC has been associated with a significant increase in outpatient encounters for individual physicians managing patients with inflammatory disease. Implementation has also been associated with high levels of patient satisfaction. Our findings indicate nursing support has become an acceptable and integral part of outpatient rheumatology care provincially, and has the potential to improve service delivery and quality of care. ■

Competing interests

None declared.

References

1. Public Health Agency of Canada. Canadian Chronic Disease Surveillance System. Accessed 28 March 2019. https://infobase.phac-aspc.gc.ca/ccdss/data-tool.
2. CATCH: Canadian Early Arthritis Cohort. Information about arthritis. Accessed 28 March 2019. www.earlyarthritis.ca/participants_education.php.
3. Widdifield J, Bernatsky S, Paterson JM, et al. Quality care in seniors with new-onset rheumatoid arthritis: A Canadian perspective. Arthritis Care Res (Hoboken) 2011;63:53-57.
4. Kur J, Koehler B. Rheumatologist demographics in British Columbia: A looming crisis. BCMJ 2011;53:128-131.
5. Sun M, Jamal S, Kur J. Analysis of rheumatology nursing interventions in out-patient practice settings. CRAJ 2014;24:18-22. Accessed 6 February 2020. http://craj.ca/archives/2014/English/Fall/PDFs/CRAJ%20Fall%202014%20-%20Sun_Jamal_Kur.pdf.
6. Saag KG, Yazdany J, Alexander C, et al. Defining quality of care in rheumatology: The American College of Rheumatology white paper on quality measurement, arthritis care and research. Arthritis Care Res (Hoboken) 2011;63:2-9.
7. Hill J, Bird H, Hopkins R, et al. Survey of satisfaction with care in a rheumatology outpatient clinic. Ann Rheum Dis 1992;51:195-197.
8. Hall JJ, Katz SJ, Car MK. Patient satisfaction with pharmacist-led collaborative follow-up care in an ambulatory rheumatology clinic. Musculoskeletal Care 2016;15:186-195.
9. Koksvik HS, Hagen KB, Rodevand E, et al. Patient satisfaction with nursing consultations in a rheumatology outpatient clinic: A 21-month randomised controlled trial in patients with inflammatory arthritis. Ann Rheum Dis 2013;72:836-843.
10. Garner S, Lopatina E, Rankin J, Marshall D. Nurse-led care for patients with rheumatoid arthritis: A systematic review of the effect on quality of care. J Rheumatol 2017;44:757-765.
11. van Eijk-Hustings Y, van Tubergen A, Bostrom C, et al. EULAR recommendations for the role of the nurse in the management of chronic inflammatory arthritis. Ann Rhuem Dis 2012;71:13-19.
12. Hill J, Bird HA, Harmer R, et al. An evaluation of the effectiveness, safety and acceptability of a nurse practitioner in a rheumatology outpatient clinic. Br J Rheumatol 1994;33:283-288.

"That Others May Live": Two weeks with the Joint Rescue Coordination Centre

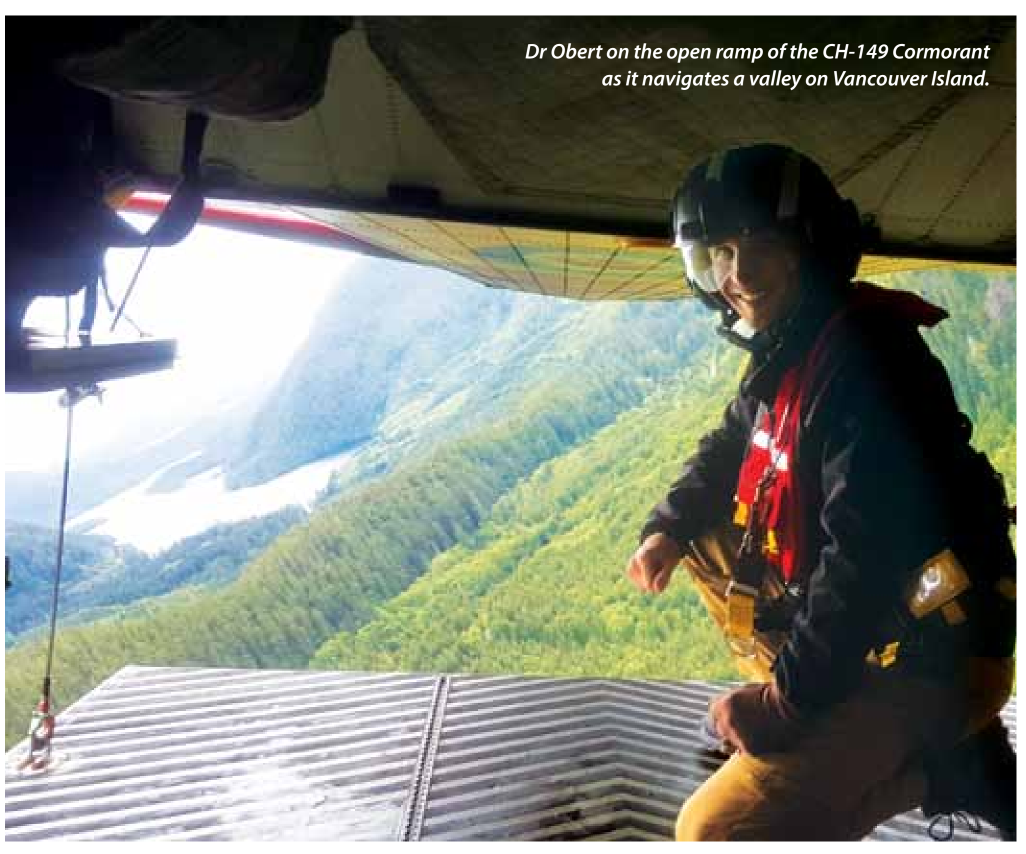
An inside look into how the centre coordinates air and maritime search and rescue for BC and Yukon.

David A. Obert, MD, MPP

Dr David A. Obert is a resident physician in his fifth year in the UBC Royal College Emergency Medicine program at Vancouver General Hospital. During his fourth year, he took additional training in prehospital and transport medicine and participated in several rotations and experiences with BC Emergency Health Services. When he completes his residency, he will pursue an emergency medical services fellowship at Stanford University.

This article has been peer reviewed.

A bush plane crashes in Yukon's wilderness. A fishing boat strikes a log off British Columbia's coast and is rapidly taking on water. A caller reports seeing several red flares in a remote area on the rugged western shores of Vancouver Island. In these and other air and sea rescue situations, the Joint Rescue Coordination Centre (JRCC) in Victoria, BC, sits atop the nexus of the fast-paced, often multi-agency response that follows. Often with limited initial information and lives on the line, search and rescue mission coordinators at the JRCC spring into action. Depending on the circumstances, a variety of resources may be tasked to respond, ranging from civilian vessels and other nearby assets to Royal Canadian Air Force planes and helicopters as well as Canadian Coast Guard vessels.



Dr Obert on the open ramp of the CH-149 Cormorant as it navigates a valley on Vancouver Island.

During 2 weeks in May 2019, I was very fortunate to get an inside look at the operations of the JRCC Victoria in fulfilling its mission to coordinate air and maritime search and rescue for BC and Yukon. As an emergency medicine resident pursuing training in prehospital and transport medicine, the experience was invaluable in offering a contrast between federally mandated search and rescue services and those of the provincially administered civilian emergency medical services system in British Columbia (BC Emergency Health Services), with which I am more familiar. While there are obvious inherent differences between search and rescue and emergency medical services, there are also areas of significant overlap and the echoes of several similar challenges. It is here, in the overlap, where we can benefit from the insights gleaned in seeing each other's worlds.

The JRCC Victoria (one of three JRCCs in Canada) is truly a joint operation. Located at Canadian Forces Base Esquimalt, Royal Canadian Air Force and Canadian Coast Guard personnel at the JRCC work together on opposite sides of a large room. The air force side of the room is staffed by a Royal Canadian Air Force air controller (an experienced pilot or air combat systems officer) who, during daytime hours, is joined by an assistant air controller. The marine side consists of two seasoned Canadian Coast Guard mariners. Despite a computer-monitor-to-person ratio of well over five to one, the room is open and designed to facilitate communication and collaboration. The marine and air search and rescue mission coordinators work 24/7 answering a variety of calls from the public, the Canadian military, the Canadian Coast Guard (and sometimes their US counterparts), RCMP, and other agencies. I even witnessed a call from the North American Aerospace Defense Command. Many are small matters—an empty boat adrift or an accidentally activated emergency locator transmitter.

Others can be multiday search operations involving multiple search and rescue mission coordinators and a variety of air and sea assets.

Generally, calls are categorized as either air, marine, or humanitarian. Air calls include monitoring notifications of distress communications picked up from pilots such as "mayday" and "pan-pan" calls. As well, all emergency locator transmitter signals (which could indicate a plane crash) that are picked up by satellites monitored at the Canadian Mission Control Centre and that fall within JRCC Victoria's search and rescue area are investigated by search and rescue mission coordinators. If a crash is determined to have occurred, JRCC then coordinates the search and rescue effort. Marine calls operate similar to air calls, but owing to the higher number of vessels on the water than aircraft in the sky, they are far more frequent. All incidents involving a threat to life or limb that occur in the waters contained within JRCC Victoria's search and rescue zone are managed by marine search and rescue mission coordinators. Such incidents may include sinking vessels, persons in the water, medical emergencies occurring at sea, and any emergency position indicating radio beacon activation (the marine equivalent of an aircraft emergency locator transmitter). Finally, humanitarian calls make up an increasing number of calls and include JRCC assistance offered in situations that otherwise fall outside its federal air and maritime search and rescue mandate. Examples include assisting land-based search and rescue agencies (such as the RCMP) as well as the BC Ambulance Service to evacuate patients from more remote and difficult-to-access areas.

Whether a call technically falls to the air or marine side does not betray the teamwork necessary for the more involved calls. The level of complexity that search and rescue mission coordinators are sometimes called on to grapple with can be mind boggling. For example, in the case of a missing person in the water, a multitude of variables—including last location, tides, currents, and wind patterns—are input into complex models to generate a search area based on predicted drift patterns. Search maps are then updated in real time to factor in continued drift, while also accounting for areas already searched. To say that the job requires a high degree of skill is an understatement.

Outside the walls of the JRCC, I also had the privilege to witness the exceptional prowess of a team of search and rescue technicians from the 442 Transport and Rescue Squadron in Comox, BC—the "pointy end of the spear" for air-based search and rescue. As part of a medical simulation exercise, I watched as the team, which had been inserted by helicopter, rushed to the scene of an incredibly realistic plane crash mock-up (complete with twisted fuselage and aircraft parts strewn about the landscape). Multiple mock casualties, played by Canadian Forces personnel, were quickly assessed and triaged as the search and rescue technicians got to work. The sound of a circling Buffalo aircraft thundered overhead, and soon after several blaze-orange parachutes appeared across the sky bringing additional personnel to the scene. The medical care that was delivered was impressive in its scope and in the ability of personnel to adapt on the fly to the fluid and technically challenging conditions. At the conclusion of the simulation exercise, several mock patients had been stabilized and remained in the capable hands of the search and rescue technicians. In a real-life scenario, the JRCC would have already been hard at work facilitating the transfer of care to the provincial trauma system.

The medical care that was delivered was impressive in its scope and in the ability of personnel to adapt on the fly to the fluid and technically challenging conditions.

However, technical skills are only one part of the equation. Equally important are the softer skills, the interpersonal aptitude necessary to coordinate effectively between multiple players in an emotionally charged, fast-moving situation. The parallels to the worlds of both emergency medicine and prehospital medicine are easy to spot. Unfortunately, so too are some of the challenges. Posttraumatic stress and burnout are ever-present issues. Recruitment and retention difficulties further burden the existing complement of search and rescue mission coordinators who are often forced to pick up extra shifts to keep the JRCC staffed 24/7/365. Additionally, as the older, experienced search and rescue mission coordinators begin to retire, there is risk of significant institutional knowledge loss.

Securing adequate funding in an era of restraint is but one factor in addressing these issues. Among other things, the JRCC must also continue to be innovative and agile in responding to challenges. Collaboration and resource pooling with related organizations is one strategy for achieving these ends and has the potential to produce mutually beneficial outcomes. The relationship between the BC Emergency Health Services' Emergency Physician Online Support program and the JRCC is a shining example of such a collaboration. The Emergency Physician Online Support program gives prehospital providers around-the-clock telephone access to a BC Emergency Health Services physician advisor for clinical decision support. BC Emergency Health Services has made the Emergency Physician Online Support service available to JRCC, as well as to Canadian Forces search and rescue technicians and Canadian Coast Guard rescue specialists. This has proven to be an invaluable resource. For example, as is the case with BC Emergency Health Services paramedics, the search and rescue technicians and rescue specialists report greatly increased confidence in their ability to provide the highest quality of patient care knowing that Emergency Physician Online Support advice is only a phone (or satellite phone) call away.

From the JRCC's perspective, a frequent issue in recent years has been calls from cruise ships for medevacs. Given the finite air and sea assets at JRCC's disposal, it is necessary to appropriately steward these resources for use where and when they are most needed. Thus, calls must be medically triaged, a task that at a command level is generally best handled by a physician. By bringing an Emergency Physician Online Support doctor on the line, physician-to-physician communication can occur with the cruise ship's medical officer and, working with the search and rescue mission coordinators, a plan using resources appropriate

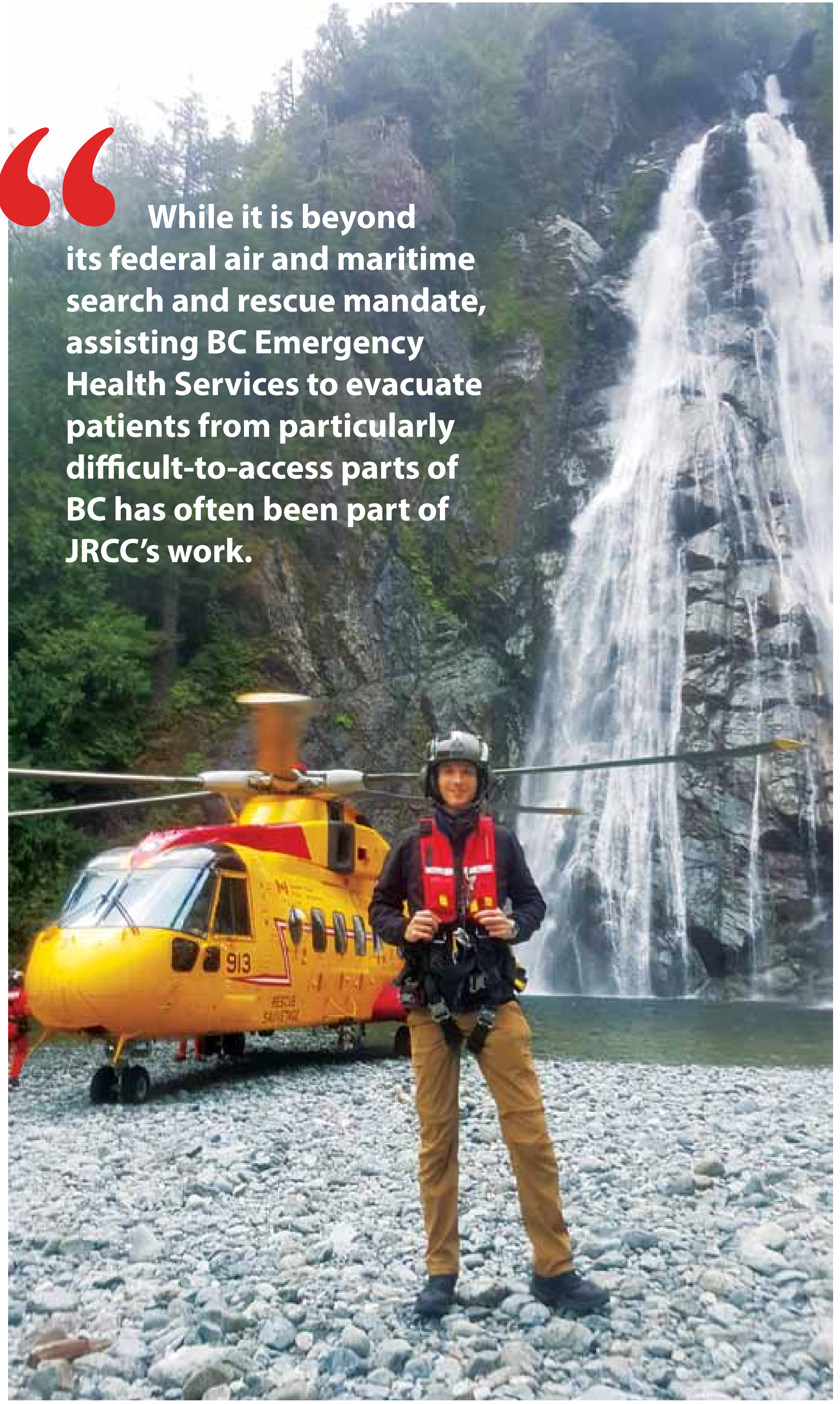
to the urgency of the medevac can be put in motion. Judging from the taped calls I listened to while observing at the JRCC, the system works exactly as designed.

It is important to note that the collaboration goes both ways. While it is beyond its federal air and maritime search and rescue mandate, assisting BC Emergency Health Services to evacuate patients from particularly difficult-to-access parts of BC has often been part of JRCC's work. Canadian Coast Guard vessels with rescue specialists aboard can reach many of the remote water-access-only communities found in BC. One would be hard pressed to find a place in BC that is beyond the combined reach of these organizations. Furthermore, patients in these remote areas can be confident that, once they are reached, they will be under the care of highly competent professionals.

Above one of the desks at the JRCC is a large Canadian flag with the motto "That Others May Live" below the words "RCAF Pararescue." Despite the many differences between federal search and rescue and the prehospital medicine world of BC Emergency Health Services, the driving motivation behind their respective efforts is the same. "That Others May Live" is part of the search and rescue technicians' pledge, and it aptly sums up this motivation. During my 2 weeks with the JRCC (and on-field excursions to 442 Squadron in Comox and two Canadian Coast Guard lifeboat stations), I saw this mentality on full display. I am extremely grateful to have been welcomed into their world. It is my hope that, through this reflection, I am able to share with the wider prehospital medicine world an understanding of the mandates, capabilities, and operations of the JRCC, Royal Canadian Air Force, and Canadian Coast Guard in delivering world-class search and rescue coverage. With this common understanding and shared ethos, collaboration between the federal air and maritime search and rescue and BC Emergency Health Services can be at its most fruitful. ■

Acknowledgments

Dr Obert would like to acknowledge and give particular thanks to Captain Sébastien Lemire, CD, and Lieutenant Philip Yoon, MD, for organizing and facilitating this unique experience with the JRCC.



"While it is beyond its federal air and maritime search and rescue mandate, assisting BC Emergency Health Services to evacuate patients from particularly difficult-to-access parts of BC has often been part of JRCC's work.

Dr Obert in front of the CH-149 Cormorant after a challenging confined space landing at the foot of a waterfall on Vancouver Island.

Group medical practice is the natural evolution of medicine

Eight core design principles that favor cooperation and the welfare of groups, applicable to the evolution of medical practice.

Mark Elliott, MD, FRCPC

The most famous quote about evolution has got to be Theodosius Dobzhansky's, "Nothing in biology makes sense except in the light of evolution." This applies to medical practice as well.

We have all been taught that Darwinian evolution is based on the principles of random mutation and natural selection. However, there are many people now questioning the completeness of these principles. There is a third principle, which is sometimes called group selection[1] and sometimes called cooperation.[2] Even Darwin had doubts about the completeness of his theory.[3]

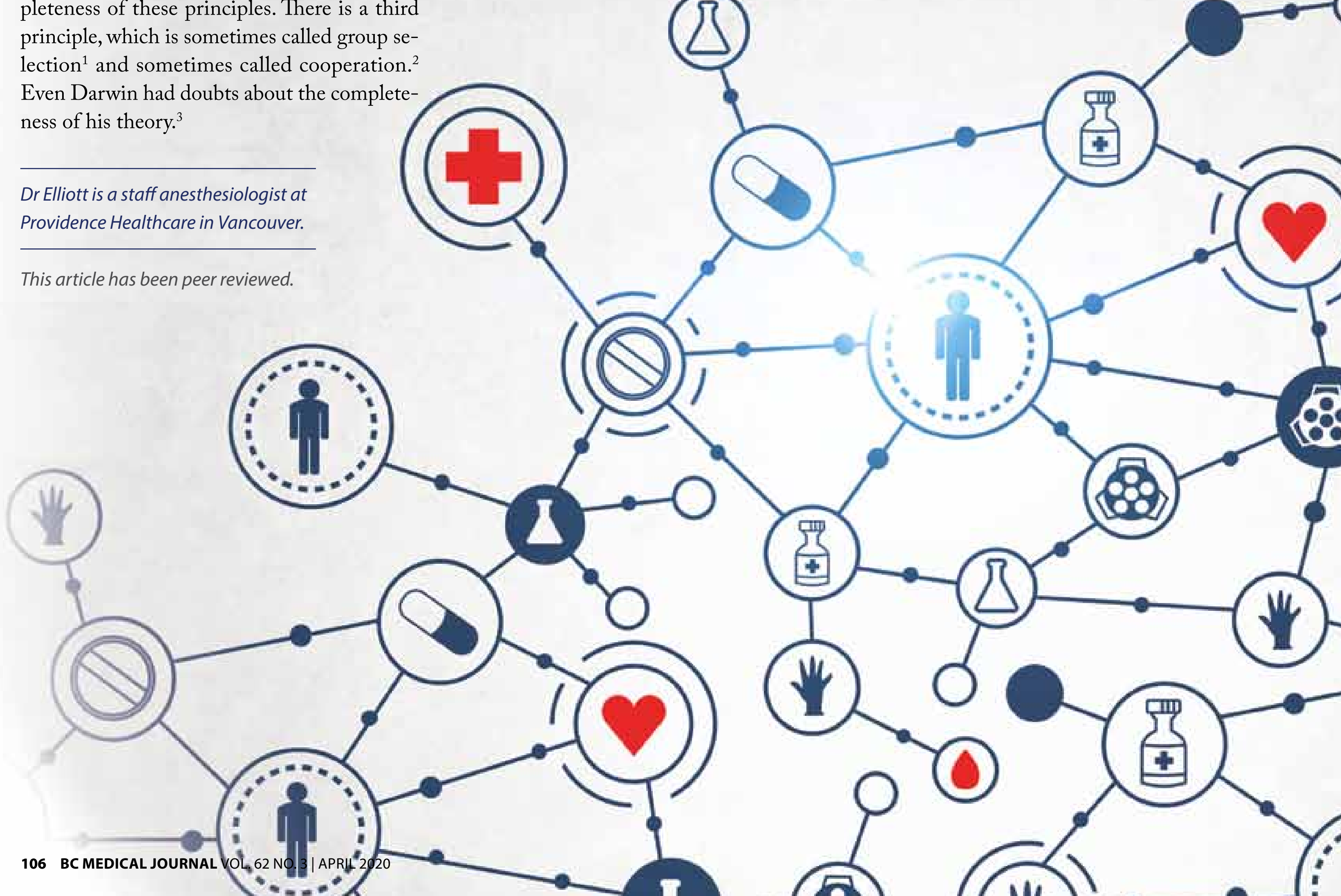
Dr Elliott is a staff anesthesiologist at Providence Healthcare in Vancouver.

This article has been peer reviewed.

For at least 50 years, biological dictum has said that it is the individual who is subject to evolution. It is now believed that the small cooperative group is the fundamental unit of an organization that evolves. In fact, the evolution probably happens at many different levels. This has been termed "multilevel selection."

And evolution is not perfect. If an adaptation is selected at one level, this inevitably creates problems the next level up. So what is good for me may not be good for my family, what is good for my family may not be good for the community, what is good for the community may not be good for the province, what is good for the province may not be good for the country, and so forth.

There is a well-known example involving hens to illustrate how group selection trumps individual selection.[4] Let's say you have groups of hens in cages (10 to a cage) on a modern agricultural egg farm. You might think that breeding the most productive individual hens would give you more eggs. But what happens after about five generations of this breeding is the hens peck each other's feathers out and egg production plummets. If, on the other hand,



you select and breed the hens in the cages that have the most eggs, production goes way up after five generations. The rational usually given for the disastrous outcome in the first scenario is that you are breeding bullies who then do nothing but fight each other. Maybe one bully in a cage of 10 hens was okay, but 10 bullies in a cage is problematic, at least as far as egg production goes.

Elinor Ostrom won a Nobel prize in economics in 2009 for outlining eight core design principles that favor cooperation and the welfare of groups.[5] This work greatly influenced biologists developing the theory of evolution at the group level.[6] These principles are very applicable to medical practice. They are outlined here.

One: Define clear group boundaries
The group must have clear boundaries so its members know they are members and know what the group does.

Two: Match rules governing the use of common goods to local needs and conditions
The group must ensure the use of common goods by individuals matches the welfare of the group. This may seem more relevant to fishers regulating some area of the sea or farmers regulating crops in fields, but it is also pertinent to group medical practice. Basically it means you can't steal your money; you must earn it.

Three: Ensure those affected by the rules can participate in modifying the rules
The group must agree to things collectively so no one individual can be bossed around.

Four: Ensure the rule-making rights of community members are respected by outside authorities
In the case of doctors, the rules they enact must be respected by the larger collective system, whether that be a hospital administration, a regional health authority, or a provincial government. This is where it is good to have a group leader who is able to communicate well with the authorities and not simply be their hired hand.

Five: Develop a system, carried out by community members, for monitoring members' behavior
There must be a system to monitor the actions of a group's members. This is where a good leader shows their other side by being able to communicate well with group members, convincing them to change a practice if it is in the interest of the group.

Six: Use graduated sanctions for rule violators
If an individual doctor in a group breaks a rule, there must be a graduated, agreed-upon system of escalating sanctions against that member. The sanctions must start out benignly and should build up to a real sting after repeated transgressions.

Seven: Provide accessible, low-cost means for dispute resolution
Disputes must be settled with very little cost to the group. If they aren't, then medicolegal problems arise. Most lawsuits stem from longstanding grudges between doctors that result in a patient either overhearing one doctor complaining about how bad another doctor is or a doctor telling that directly to the patient. If a disastrous complication results from some situation, it is much easier for the individual doctor if everyone in the group does things similarly and/or jointly. Think about the difference between one surgeon struggling for hours versus two surgeons together struggling for hours with a bad outcome.

Eight: Build responsibility for governing the common resource in nested tiers from the lowest level up to the entire interconnected system
Interconnectedness is what defines a complex adaptive system. Health care is just one of many such systems. Johnny von Neumann said that the defining characteristic of a complex system is that it constitutes its own simplest behavioral description. If we try to reduce the system's behavior to any formal description it makes things more complicated, not less. This seems rather demoralizing in our health care system, but the responsibility that Ostrom's eighth principle suggests needs to be developed is better than anarchy.

Evolution is not top-down like the hierarchy of the military or hospital administration. Nor is it completely bottom-up, with evolution only working its wonders on genes that mutate and then get randomly selected (like laissez-faire capitalism with its inevitable booms and crushing busts). Evolution tinkers with things. It experiments, lets most things fail, and keeps the things that work until they, too, fail. Medical practice is no different. ■

References

1. Wilson DS. This view of life. Completing the Darwinian revolution. New York, NY: Penguin Random House; 2019.
2. Nowak MA, Highfield R. Supercooperators. Altruism, evolution, and why we need each other to succeed. New York, NY: Free Press; 2012.
3. Darwin C. On the origin of species by means of natural selection, or preservation of favoured races in the struggle for life. London, John Murray; 1859.
4. Muir W. Group selection for adaptation to multiple hen cages. Poultry Sci 1996;75:447-458.
5. Ostrom E. Governing the commons: The evolution of institutions for collective action. Cambridge, UK: Cambridge University Press; 1990.
6. Wilson DS, Ostrom E, Cox M. Generalizing the core design principles for the efficacy of groups. J Econ Behav Organ 2013;90:S21-S32.

News

We welcome news items of less than 300 words; we may edit them for clarity and length. News items should be emailed to journal@doctorsofbc.ca and must include your mailing address, telephone number, and email address. All writers should disclose any competing interests.

Register now for the Business Cost Premium

The new Business Cost Premium (BCP) was negotiated in the 2019 Physician Master Agreement to help physicians offset some of the costs associated with running their office. Physicians will be able to claim the BCP on fees for consultation, visit, counseling, and complete examination services to help cover the rising rent, lease, or ownership costs of a community-based office. Physicians need to register their facility and attach themselves as a practitioner of the facility. The BCP came into effect 1 April 2020.

Eligible physicians are those who provide eligible services in an eligible community-based office and who are responsible for some or all of the lease, rental, or ownership costs of that office, either directly or indirectly. Physicians must also be entitled to receive and retain payment for the eligible fees directly from MSP (that is, payments assigned to health authorities are not eligible for the premium).

The BCP will be applied to eligible fees submitted on a physician's billing claims, and will be paid to the physician's (or assigned) payee number. The claims system will apply the percentage for the premium and calculate the daily maximum. In order to identify the physical location in which services are provided and for the correct percentage premium to be applied, physicians need to register their community-based office for a facility number, which is a unique physician/office location-identifier.

If an eligible physician is responsible for some or all of the lease, rental, or ownership costs at more than one community-based location, they need to register each location where eligible services are provided.

Community-based offices with multiple eligible physicians should assign one physician to act as the administrator and register the office for a facility number. It is not required that all physicians in the same clinic apply for a facility number. However, each eligible physician is required to complete an Attach Practitioner to MSP Facility Number application form using the facility number obtained by your administrator.

See the "Business Cost Premium links" box for links to forms and more information.

Business Cost Premium links

List of eligible fees

- www.doctorsofbc.ca/sites/default/files/bcp_eligible_fees_current.xlsx

Online application

- Apply for facility number: https://my.gov.bc.ca/bcp/register-facility
- Attach practitioner to MSP facility number: https://my.gov.bc.ca/bcp/practitioner-registration

Fill and print forms

- Apply for facility number: www2.gov.bc.ca/assets/gov/health/forms/2948fil.pdf
- Attach practitioner to MSP facility number: www2.gov.bc.ca/assets/gov/health/forms/2950fil.pdf

For more information

- www.doctorsofbc.ca/news/what-you-need-know-about-business-cost-premium

Benefits of accelerated surgery in patients with hip fracture

Accelerated time to surgery—within an average of 6 hours after a hip fracture diagnosis—resulted in a lower risk of delirium and urinary tract infections, moderate to severe pain, faster mobilization, and a shorter length of hospital stay compared to standard care (when surgery occurred an average of 24 hours after a hip fracture diagnosis).

The HIP Fracture Accelerated Surgical Treatment and Care Track (HIP ATTACK) Trial, published in *The Lancet*, was led by researchers of the Population Health Research Institute (PHRI) of McMaster University and Hamilton Health Sciences (HHS) in Hamilton. HIP ATTACK involved 2970 people at 69 sites in 17 countries.

Ten years ago, Dr P.J. Devereaux, principal investigator of the HIP ATTACK trial, as well as senior scientific lead of PHRI's perioperative and surgery program, professor of medicine at McMaster, and cardiologist with HHS, was consulted to manage a 73-year-old female with a hip fracture who also had elevated troponin, demonstrating heart injury. The referring doctor told Dr Devereaux the patient's heart issue had to be treated before surgery for her hip fracture could occur. Despite the best of intentions, with the medical treatment Dr Devereaux provided based on current practice at that time, the patient died before she was able to undergo surgery for her hip fracture.

Dr Devereaux wondered if the prevailing dogma regarding the need to medically optimize patients before hip fracture surgery was the wrong approach. He contacted Dr Mohit Bhandari, co-principal investigator of HIP ATTACK and an orthopaedic surgeon in Hamilton, to get his perspective on the case. Dr

Bhandari told Dr Devereaux that observational studies suggested that shorter time to surgery may prevent death and major complications in patients with a hip fracture. Based on this evidence, they initiated a large randomized controlled trial to understand the effects of accelerated surgery in patients with a hip fracture.

Accelerated surgery did not result in a reduction in death or a collection of major complications; however, patients randomized to accelerated surgery had a lower risk of delirium, urinary tract infection, moderate to severe pain, and were faster to stand, mobilize, and go home compared to patients randomized to standard care. Among patients who had elevated troponin when they presented to the hospital with their hip fracture, accelerated surgery lowered the risk of death compared to standard care.

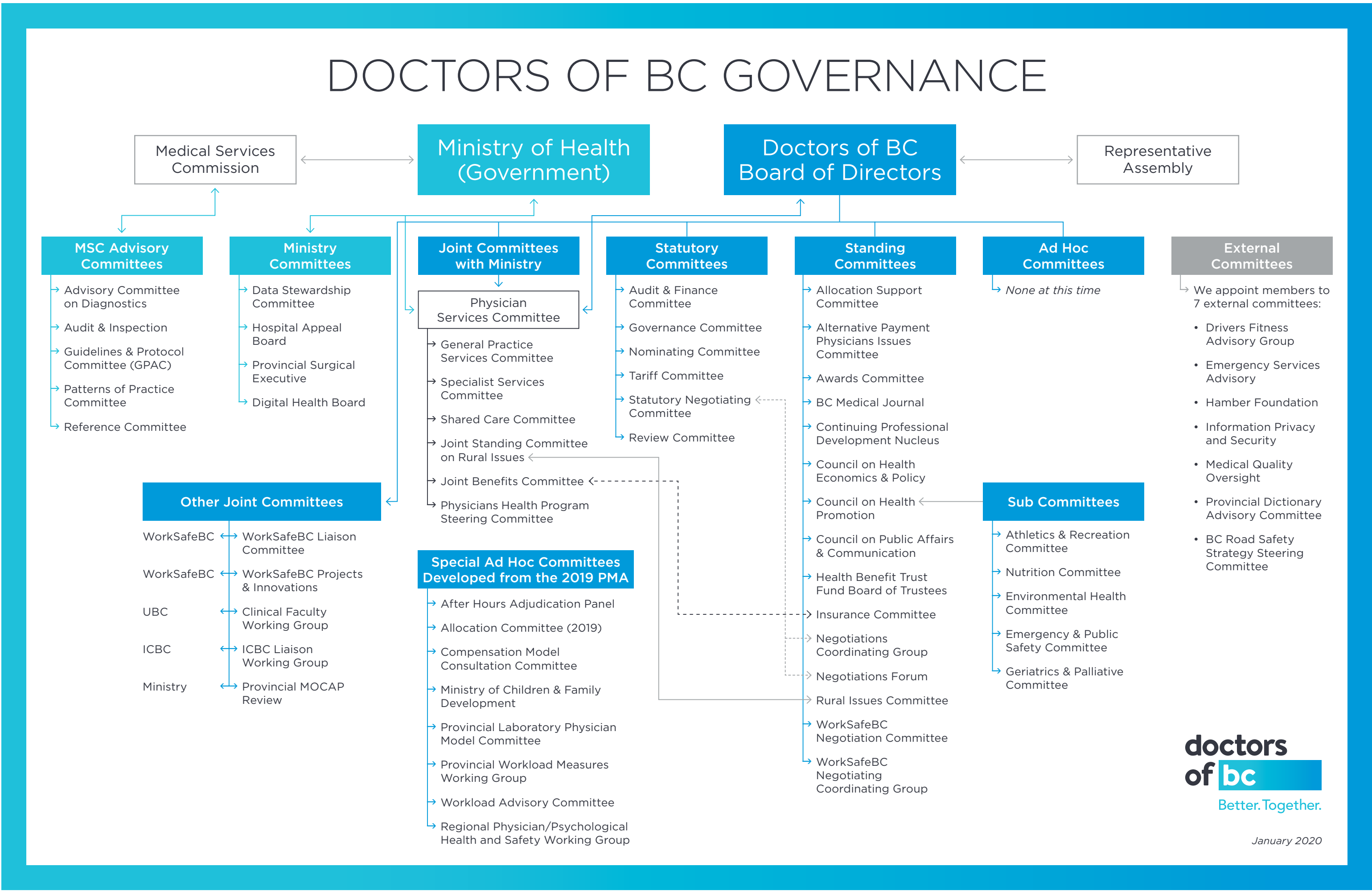
Physical activity for prostate cancer patients and its effect on tumors

Prostate cancer affects 15% to 20% of North American men. Living with a cancer diagnosis can be frightening and anxiety-inducing, but at the same time there exists a hopeful phenomenon called the "teachable moment." The teachable moment describes cancer patients' increased likelihood of accepting and acting on their health care provider's lifestyle change recommendations because of their diagnosis. Vancouver Coastal Health Research Institute scientist Dr Ryan Flannigan is currently studying whether the teachable moment offers an opportunity to get prostate cancer patients into a regular exercise routine that may change the genetic expression and molecular makeup of their tumor and improve their diagnosis.

Dr Flannigan is a urologist focused on men's health at Vancouver General Hospital and senior research scientist at the Vancouver Prostate Centre. He is also clinical lead of the Prostate Cancer Supportive Care Sexual

Doctors of BC governance and committee reporting structure

This graphic was created by Doctors of BC senior staff as a tool to help the Board of Directors, the Representative Assembly, members, and staff visualize and better understand the complex relationships and reporting structures of the committees and other bodies represented.



Medicine Program, British Columbia, director of the Male Infertility & Sexual Medicine Research Program, and assistant professor in the Department of Urologic Sciences at UBC.

There have been a number of research studies on a population level that have identified the association between exercise and reduced risk for acquiring prostate cancer, prostate cancer-specific mortality, and delayed disease progression. Studies have also shown a connection between regular exercise and improved quality of life for patients in terms of alleviating treatment-associated side effects such as fatigue and decreased muscle strength and physical function.

Dr Flannigan's study participants were 20 men diagnosed with immediate-risk prostate cancer, meaning eventual surgery to remove the prostate gland. Ten participants were randomly assigned to an 8- to 12-week exercise intervention completed prior to surgery. The intervention comprised two 1-hour sessions of supervised resistance and aerobic training per week, as well as home aerobic training at least twice weekly. The other 10 participants received standard prostate cancer care that included education about healthy exercise and diet.

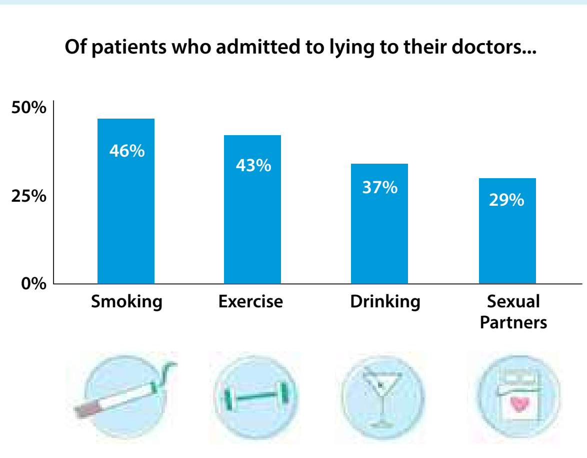
The study found that introducing exercise during the teachable moment (after diagnosis and before surgery) led to increased physical activity among participants 6 months post-surgery and well after the exercise intervention period. The study also found that prostate cancer–specific quality of life and depressive symptoms were similar 6 months after surgery as before surgery.

Studies using animal models have demonstrated decreased tumor activity following exercise treatments. For example, research suggests that exercise may interfere with oxygen delivery in prostate cancer tumor microcirculation and tumor proliferation, decreasing chances of the cancer spreading to other parts of the body and delaying tumor growth.

As part of their study, Dr Flannigan and his team are testing participants' tumor specimens to see if there are any changes resulting from the exercise intervention. They hope to have preliminary molecular and genetic study results by summer 2020.

What patients lie to their doctors about, and why

Doctors know that patients are not always fully truthful with them, but just how much do patients lie, and about what? A recent Pollfish survey found that 43% of those who admitted to lying say they lie about their exercise habits; the only thing that more people admitted to lying about was smoking (46%). Patients 35 and older were more likely to lie about their exercise habits than younger patients, while those under 35 were more likely to lie about smoking.



More men lied to doctors about alcohol consumption than women (50% men vs. 32% women), while women were more likely to lie about sexual partners (33% women vs. 21% men).

Why are patients lying?

- 75% of respondents cited embarrassment.
- 31% lie to avoid discrimination.
- 22% lie because they don't think their doctor will take them seriously if they tell the truth.

Of those who admitted to lying to their physician, the group that lied to avoid discrimination was overwhelmingly female (80% female, 20% male).

On the bright side, in general most people (77% of those surveyed) are honest with their doctor, and 34% said they were comfortable talking with their doctor about *anything*.

The survey was conducted for insurance aggregator TermLife2Go, and had 500 respondents from throughout the US. More results are available at https://termlife2go.com/lying-to-your-doctor.

Cloud-based clinical speech recognition has at last come to Canada!

- Dictate from almost anywhere.
- Use your Smartphone as a microphone.
- Automatic accent detection.
- No per-device limits.
- Installs in minutes.

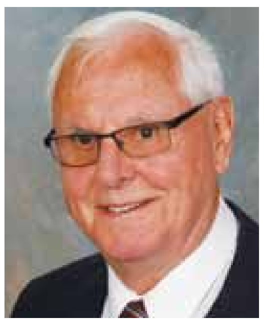
Nuance® Dragon® Medical One

Contact us today for a free trial!
604-264-9109 | 1-888-964-9109

speakeasysolutions.com
Professional Speech Technology Specialists

Obituaries

We welcome original tributes of less than 300 words; we may edit them for clarity and length. Obituaries may be emailed to journal@doctorsofbc.ca. Include birth and death dates, full name and name deceased was best known by, key hospital and professional affiliations, relevant biographical data, and a high-resolution head-and-shoulders photo.



Dr Hans Adalbert Witt
1934–2020

Dr Hans Adalbert Witt was born in Brasdorf, East Prussia, on 29 August 1934. At the outbreak of World War II, Hans's life changed in ways that would shape his character and influence his legacy of tenacity.

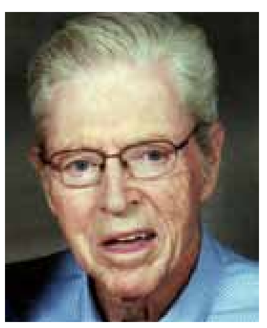
In 1945, Hans, his seven siblings, and their mother fled to Schleswig-Holstein. There, Hans completed his schooling and apprenticed as a tool and die maker. In 1955 the family, sponsored by the Mennonite Church, immigrated to Canada and settled on a farm in Virgil, Ontario. To support his family, Hans worked as a newspaper truck driver and then as a tool and die maker with GM. During this time, he took courses at night to learn English, and his hard work saw him enter medical school. He became a family doctor and then specialized in anesthesia. He married Nancy McAdam and they lived in various towns in BC with their two children, Heidi and Jonathan. Sadly, his marriage did not continue.

In 1994, Hans returned to Toronto and began practising psychotherapy. He retired in 2005. On a visit to Kelowna, he met Ela Jackel and their beautiful relationship began. In addition to dancing and gardening with Ela, Hans was an avid bridge player.

As a young immigrant, his career was shaped by his mother's words that "education will save your life." His passion for lifelong learning was evidenced when he became a student once more and, at age 82 at UBC Okanagan, achieved his dream of attaining a Bachelor of Arts degree. Indeed, he is a role model for anyone whose life circumstances are challenging. His love of learning is indeed a legacy he leaves the next generation of family.

In 2018, Hans was diagnosed with cancer. He underwent surgery and radiation, but in December his health challenges increased. He died peacefully at Kelowna Hospice House on 21 January 2020.

—Heidi Grogan
Calgary



Dr Barry King Cutler
1937–2019

Dr Barry King Cutler, 82 years of age, passed away peacefully at the Berkley Care Centre on 16 December 2019, surrounded by family.

A man of faith, Barry is lovingly remembered by his wife of 58 years, Judith; his children, Duffy (Shari) and Rob (Joanne); his sister, Diane (Doug Porter); his grandchildren, Cameron, Emily, and McKenzie, and Gemma and Declan. He will also be remembered by many friends and colleagues from Canada, the United States, and Mexico. Barry was predeceased by his mother, Wilma (nee King); his father, Don; and his eldest son, Scott.

A loving husband and father, Barry was a compassionate physician and surgeon in the Powell River area for 32 years. After Barry completed his high school education at University of Toronto Schools and medical training at the University of Toronto, he and Judy left extended family and moved to BC in 1968 to raise a family and begin a lifelong mission of caring for the members of Powell River's thriving coastal community. Barry was president of the BC Surgical Society (1986–87) and president of the Powell River Medical Society (1991–95).

Barry was an avid athlete, farmer, outdoorsman, mariner, and fan of all things related to sports. A pioneer in every sense of the word, and a gentle spirit, Barry would count his contributions to the Powell River community among his proudest accomplishments. He was recently named to the Powell River Sports Hall of Fame as team physician for the Power River Regals Hockey Club and its run to the Allan Cup championship in 1969. He was a member of the medical team at the Montreal Olympic Games, and as president of the Powell River Golf Club (1984–88), he was instrumental in initiating the planning and construction of the Myrtle Point Golf Club.

In 2000 Barry and Judy began spending winters in Ajijic, Mexico, and in 2013 they moved to North Vancouver to be closer to family. In 2006, Barry began a 13-year battle with Parkinson disease and Lewy body dementia. His family thanks Drs Doug Toole, Steve Burns, Silke Cresswell, Arvind Kang, and Garry Jenkins, and the nurses, care aids, and staff of Berkley Care Centre for their exceptional and dedicated care for Barry over the years and during his 3½ years living at the care centre.

A Mass of Christian Burial was held on 15 January 2020 at Christ the Redeemer Parish, 599 Keith Road, West Vancouver. Please visit Barry's online memorial page at www.mckenziefuneralservices.com for more information and to post to the online book of condolences. In lieu of flowers, memorial donations may be made to the Pacific Parkinson's Research Institute: www.pacificparkinsons.org.

—Judith Cutler, MD
North Vancouver

CME calendar

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. **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. **Planning your CME listing:** Advertising your CME event several months in advance can help improve attendance; we suggest that your ad be posted 2 to 4 months prior to the event. **Ordering:** 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.

MINDFULNESS IN MEDICINE WORKSHOPS & RETREATS

Various locations and dates, 17 Apr–24 May

Physician heal thyself. Join Dr Mark Sherman and your community of colleagues for a transformative retreat! Foundations of Theory and Practice Workshop for Physicians and Their Partners, 17–20 Apr and 25–28 Sep, will be held at Long Beach Lodge Resort, Tofino. A Physician Meditation Retreat, 24–29 May, will be held at Hollyhock, Cortes Island. The workshops focus on the theory and practice of mindfulness and meditation—reviewing definitions, clinical evidence, and neuroscience, and introducing key practices of self-compassion, breath work, and sitting meditation to nurture resilience and healing. This annual meditation retreat is an opportunity to delve deeply into meditation practice in order to recharge, heal, and build a practice for life. Each workshop is accredited for 16 Mainpro+ group learning credits and has a 30-person limit, so please register today! Contact us at hello@livingthismoment.ca, or check out www.livingthismoment.ca/event for more information.

EVERYTHING VESTIBULAR

Vancouver, 23 Apr (Thu)

To be held at St. Paul's Hospital, Cullen Family Lecture Theatre (Rm. 1477), 1400–1081 Burrard St., this will be a panel presentation of specialists in the fields of vestibular medicine and rehabilitation. Though dizziness is one of the most common reasons for consulting a physician, establishing an accurate diagnosis and treatment plan can be tricky. In recent years, great strides have been made to understand, evaluate, and manage vestibular disorders better. This panel presentation brings together passionate specialists from the fields of vestibular medicine and rehabilitation who aim to provide the most up-to-date, evidence-informed intelligence about vestibular care. We hope the audience will leave with a better understanding of the relationship between vestibular diagnosis and appropriate management and intervention. Speakers (5 p.m. to 9 p.m.): Dr Margaret Aron, MD, FRCSC, ENT specialist neurotology; Fred Matta, MClinAud, R AUD, RHIP, audiology specialist; Abeed Hirji, OT, certified vestibular therapist, 2007. The evening's format will include dinner, presentations, and panel Q&A. For full event details, a detailed agenda, and to register (by 12 April) visit: http://bit.ly/EverythingVestibular.

CME ON THE RUN

VGH and various videoconference locations, 1 May–5 Jun (Fri)

CME on the Run sessions are held at the Paetzold Lecture Theatre, Vancouver General Hospital, and there are opportunities to participate via videoconference from various hospital sites. Each program runs on Friday afternoons from 1 p.m. to 5 p.m. and includes great speakers and learning materials. Dates and topics: 1 May (prenatal, pediatric, and adolescents). Topics include Management of anxiety in children; Pediatric asthma management update; Abnormal gait in children: Diagnosis and management; ADHD: Clinical tips for diagnosis and treatment; Depression in teens; Management of childhood obesity; Doc, I'm pregnant. Now what? An update on antenatal screening; Pediatric rashes. The last session is 5 Jun (internal medicine). To register and for more information visit ubccpd.ca, call 604 675-3777 or email cpd.info@ubc.ca.

TROPICAL & GEOGRAPHIC MEDICINE INTENSIVE

Vancouver, 4–8 May (Mon–Fri)

This is the 7th annual CME accredited course for physicians, medical trainees, public health practitioners, nurses, and other health care workers who intend to practise in the tropics, in resource-limited settings, or who require an update on infectious, parasitic, and other major tropical diseases. The course will be held at the UBC Vancouver campus. Through interactive lectures, small-group case-based discussions, and practical laboratory teaching, attendees will learn a clinical approach to the evaluation and management of tropical diseases, practical laboratory skills with a focus on the identification of parasites important for the diagnosis of tropical diseases, and public health principles and applications including outbreak management. Early registration rate effective until 6 April 2020. Register early on the course website as space is limited. More information at www.spph.ubc.ca/continuing-education/tgm2020/. Contact spph.ce@ubc.ca.

HEALTHCARE PROVIDERS CONFERENCE

Victoria, 14 May (Thu)

Join us for an evening of educational sessions at LifeLabs 4th Annual Healthcare Providers Conference to be held at the beautiful Oak Bay Beach Hotel, 1175 Beach Dr. If you think of laboratory medicine as a "black box," or if you would like to know more about ordering and interpreting lab testing, or if you'd like to connect with lab medicine specialists, this is the conference for you. Topics will be of interest to GPs and specialists, nurse practitioners, naturopathic doctors, and allied health care providers—particularly those providing primary

care and ordering and interpreting lab tests. Our PhD and MD laboratory medicine staff includes specialists in biochemistry/toxicology, hematology, microbiology/infectious diseases, and genetics. They will share their expertise through formal presentations and also be available for informal discussion before and after the sessions. Presentations will use a case-based format to address clinical topics in laboratory test selection and interpretation. A complete list of presentation topics will be posted to our website closer to the meeting date. Conference registration includes a free gourmet buffet dinner and nonalcoholic beverages. This educational event may qualify up to 2 hours of unaccredited group learning activity. Registration is free. Sign up now as space is limited: www.lifelabs.com/annual-conference.

CANADIAN CONFERENCE ON PHYSICIAN LEADERSHIP
Vancouver, 29–30 May (Fri–Sat)
The Canadian Conference on Physician Leadership—Accepting Our Responsibility as Physician Leaders will be held at the Hyatt Regency Hotel. This 2-day educational event brings together physician leaders from across Canada and internationally and is designed to engage and educate physician leaders at all levels. Take advantage of our four 2-day intensive and interactive preconference courses (27–28 May). For more information email carol@physicianleaders.ca, or visit www.physicianleadershipconference.com.

GP IN ONCOLOGY TRAINING
Vancouver, 14–25 Sep and 8–19 Feb 2021 (Mon–Fri)
BC Cancer's Family Practice Oncology Network offers an 8-week General Practitioner in Oncology education program beginning with a 2-week introductory session every spring and fall at BC Cancer–Vancouver. This program provides an opportunity for rural family physicians, with the support of their community, to strengthen their oncology skills so that they can provide enhanced care for local cancer patients and their families. Following the introductory session, participants complete a further 30 days of clinic experience at the Cancer Centre where their patients are referred. These are 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.

2,300 BC pedestrians are injured in car crashes every year.

Doctors of BC has launched a safety campaign to help make the province's roadways a safer place for pedestrians.

BE SEEN
KEEP YOUR HEAD UP
USE CROSSWALKS
EYE CONTACT IS KEY

Let British Columbians know that the province's physicians care about their safety by hanging a free poster in your office and providing reflective armbands for your patients.

doctors of bc

To get posters and armbands for your practice, email: communications@doctorsofbc.ca

Why become a medical inspector?

From time to time you will see requests for medical inspectors or audit hearing panel members, and you may wonder why anyone would want to be a medical inspector and audit their peers.

The Medical Services Commission (MSC) is responsible for administering the Medical Services Plan (MSP), which includes remunerating physicians. As part of administering MSP, audits are conducted to ensure physicians have appropriate billing patterns.

Having a peer physician conduct the review is preferred by both the AIC and the physician undergoing the audit and inspection.

As a medical inspector, you will participate in one or more audits by reviewing medical records to assess whether a physician's MSP billings comply with billing rules. In this interesting and rewarding role, you will be making decisions about appropriate billing practices in accordance with the MSC payment schedule, and you will also help provide explanations to the physician who is being audited. If appointed as a medical inspector, you will be placed on a call list and asked to participate in audits related to your specialty and/or scope of practice. If you are called, the audit will be scheduled based on your availability, and you will have the option to decline to participate if you are unavailable at that time.

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

When the Audit and Inspection Committee (AIC) requests an on-site audit of a medical practice, an attempt is made to match the medical inspector with the type of practice being audited. Having a peer physician conduct the review is preferred by both the AIC and the physician undergoing the audit and inspection.

The AIC is accepting applications for medical inspectors from any section, but it is currently looking to fill medical inspector roles for the following specialties:

- General practice
- Pediatrics
- Infectious diseases
- Neurosurgery
- Endocrinology
- Neurology
- Psychiatry
- Otolaryngology
- Anesthesiology
- Sleep medicine
- Internal medicine and other medical subspecialties
- General surgery and other surgical subspecialties

Inspectors are appointed by the AIC under the Medicare Protection Act. Inspectors are responsible for reviewing medical records in order to assess compliance with the MSC Payment Schedule, the Act, and the Regulations.

Conditions of appointment

Candidates must:

- Have a minimum 5 years' experience in the applicable specialty.
- Be an active registrant with the College of Physicians and Surgeons of BC.
- Have billing practices that fall within the accepted standards of the profession or generally designated by the Patterns of Practice Committee.
- Have the ability to exercise sound judgment.
- Have an understanding and knowledge of the MSC payment schedule.
- Not be subject to circumstances that could give rise to a conflict of interest.

Inspectors are required to:

- Sign a 3-year contract, with possible extension, to be placed on a call list with the Ministry of Health. Once under contract, medical inspectors will be contacted to conduct audits on an as-needed basis. If a medical inspector is contacted, the audit will be scheduled based on the medical inspector's availability.
- Attend an orientation and training session.
- Attend on-site audits, which may include travel and stay at accommodations outside the medical inspector's city (length varies from 3 to 5 days).
- Work as part of a team with members of the Billing Integrity Program while on site.
- Inspect medical records, make determinations about compliance with the payment schedule, and flag any quality-of-care concerns.
- Have an exit interview with the auditee to clear up any unanswered questions or obtain explanations of billing issues.
- Review and sign the final audit report.
- Act as a witness before a panel established under the Act, if necessary.
- Maintain confidentiality and independence at all times as required by Section 49 of the Act.

Compensation

Medical inspectors are paid an hourly rate derived from the hourly equivalent of Doctors of BC's sessional rate for GPs or specialists. Inspectors also receive compensation for eligible travel expenses.

If you are interested in becoming a medical inspector, please contact Tara Hamilton, project coordinator, audit and billing, at 604 638-6058 or thamilton@doctorsofbc.ca. ■

—Nick Szpakowicz, MD
Vice-Chair, Patterns of Practice Committee

Guidelines for authors (short form)

The *British Columbia Medical Journal* welcomes letters, articles, and essays. 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. Send submissions to: The Editor, *BC Medical Journal*, journal@doctorsofbc.ca.

For all submissions

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

Clinical articles/case reports

Manuscripts of scientific/clinical articles and case reports should be 2000 to 4000 words in length, including tables and references. Email to journal@doctorsofbc.ca. The first page of the manuscript should carry the following:

- Title, and subtitle, if any.
- Preferred given name or initials and last name for each author, with relevant academic degrees.
- 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 Gynecology at the University of British Columbia and a staff gynecologist at Vancouver Hospital."
- A structured or unstructured abstract of no more than 150 words. If structured, the preferred headings are "Background," "Methods," "Results," and "Conclusions."
- Three key words or short phrases to assist in indexing.
- Name, address, telephone number, and e-mail address of corresponding author.

Authorship, copyright, disclosure, and consent form

When submitting a clinical/scientific/review paper, all authors must complete the *BCMJ*'s four-part "Authorship, copyright, disclosure, and consent form."

1. Authorship. All authors must certify in writing that they qualify as an author of the paper.
Order of authorship is decided by the co-authors.

2. Copyright. All authors must sign and return an "Assignment of copyright" prior to publication. Published manuscripts become the property of the BC Medical Association and may not be published elsewhere without permission.

3. Disclosure. All authors must sign a "Disclosure of financial interests" statement and provide it to the *BCMJ.* This helps reviewers determine whether the paper will be accepted for publication, and may be used for a note to accompany the text.

4. Consent. If the article is a case report or if an individual patient is described, written consent from the patient (or his or her legal guardian or substitute decision maker) is required.

Papers will not be reviewed without this document, which is available at www.bcmj.org.

References to published material

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: For more than three authors, list first three, followed by "et al.")

2. Mollison PL. Blood Transfusion in Clinical Medicine. Oxford, UK: Blackwell Scientific Publications; 2004:178-180.
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; 2005:1367-1372.
4. Health Canada. Canadian STD Guidelines, 2007. www.hc-sc.gc.ca/hpb/lcdc/publicat/std98/index.html (accessed 15 July 2018).

(NB: The access date is the date the author consulted the source.)

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 2017).

Material submitted for publication but not accepted should not be included.

Permissions

It is the author's responsibility to obtain written permission from both author and publisher for material, including figures and tables, taken or adapted from other sources. Permissions should accompany the article when submitted.

Tables and figures

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.

Tables. Please adhere to the following guidelines:

- Submit tables electronically so that they may be formatted for style.
- Number tables consecutively in the order of their first citation in the text and supply a brief title for each.
- Place explanatory matter in footnotes, not in the heading.
- Explain all nonstandard abbreviations in footnotes.
- Ensure each table is cited in the text.

Figures (illustrations). Please adhere to the following guidelines:

- Send scans of 300 dpi or higher.
- Number figures consecutively in the order of their first citation in the text and supply a brief title for each.
- Place titles and explanations in legends, not on the illustrations themselves.
- Provide internal scale markers for photomicrographs.
- Ensure each figure is cited in the text.
- Color is not normally available, but if it is necessary, an exception may be considered.

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).

Full guidelines

Please see www.bcmj.org/submit-article for the full Guidelines for Authors.

Classifieds

Advertisements are limited to 700 characters. Rates: Doctors of BC members: $50 + GST per month for each insertion of up to 350 characters. $75 + GST for insertions of 351 to 700 characters. Nonmembers: $60 + GST per month for each insertion of up to 350 characters. $90 + GST for insertions of 351 to 700 characters. **Deadlines:** Ads must be submitted or canceled by the first of the month preceding the month of publication, e.g., by 1 November for December publication. Visit www.bcmj.org/classified-advertising for more information. **Ordering:** Place your classified ad online at www.bcmj.org/classified-advertising. Payment is required at the time that you place the ad.

EMPLOYMENT

ARE YOU A PHYSICIAN LOOKING FOR A NEW ROLE?
Physicians for You—leaders in physician recruitment in Canada. Our strong reputation is built on exceptional service and results. Locum, contract, long-term, city, rural, we have it all. Whether you're a physician looking for work across Canada, or a medical facility requiring physicians, we can help. Your needs are our focus. Save time and effort; let us do all the legwork. Let our 10 years of experience in Canada, extensive knowledge of the processes for licensure, and our personalized, friendly service work for you. Check out our current job postings online and contact us today. Website: www.physiciansforyou.com. Email: info@physiciansforyou.com. Office: 1 778 475-7995.

BURNABY—PSYCHIATRIST, SFU, HEALTH AND COUNSELLING SERVICES
Simon Fraser University's Health and Counselling Services is seeking a part-time psychiatrist to join its multidisciplinary team providing services to domestic and international university students at the SFU Burnaby campus. Our mental health team includes physicians, mental health nurses, a transition case manager, case manager, psychologists, registered clinical counselors, and counseling interns. Compensation is provided via a combination of fee-for-service (MSP), sessional payments, and a service contract agreement. Applicants must have FRCPC and be eligible for full licensure with CPSBC. Please contact Dr Patrice Ranger at pranger@sfu.ca or HCS director Martin Mroz at mmroz@sfu.ca. See our website at www.students.sfu.ca/health.

EDMONTON, AB—FAMILY PRACTICE PHYSICIAN REQUIRED
Callingwood Crossing Medical Clinic is vibrant and growing! West Edmonton location. Newly renovated dynamic office operating for over 28 years with an extremely loyal patient base. We use Med Access EMR, have an attached pharmacy, and are one of the largest clinic members of Edmonton West Primary Care Network. We have immediate openings for a physician with enough patient volume where your panel could be filled in 3 to 6 months. You would work as an independent contractor with a fee-for-service split. We also offer an attractive signing bonus and look forward to hearing from you soon! Please email Amy Markovitz, Amy.ccmc@hotmail.com, or Nanci Harper, nanci_anne@hotmail.com.

KELOWNA—CHIEF MEDICAL HEALTH OFFICER
Interior Health is seeking a chief medical health officer (CMHO) to fulfill the role of chief of medical and population health services for the beautiful Southern Interior region of BC. Located in Kelowna, the CMHO is responsible for leading public health, health promotion and prevention, and health protection in addition to overseeing the work of Interior Health's medical health officers. For details or to apply online, visit https://jobs.interiorhealth.ca/job/kelowna/chief-medical-health-officer/602/15219666.

NANAIMO—GP
General practitioner required for locum or permanent positions. The Caledonian Clinic is located in Nanaimo on beautiful Vancouver Island. Well-established, very busy clinic with 26 general practitioners and two specialists. Two locations in Nanaimo; after-hours walk-in clinic in the evening and on weekends. Computerized medical records, lab, and pharmacy on site. Contact Lisa Wall at 250 390-5228 or email lisa.wall@caledonianclinic.ca. Visit our website at www.caledonianclinic.ca.

NORTH VAN—FP LOCUM
Physician required for the busiest clinic/family practice on the North Shore! Our MOAs are known to be the best, helping your day run smoothly. Lucrative 6-hour shifts and no headaches! For more information, or to book shifts online, please contact Kim Graffi at kimgraffi@hotmail.com or by phone at 604 987-0918.

POWELL RIVER—LOCUM
The Medical Clinic Associates is looking for short- and long-term locums. The medical community offers excellent specialist backup and has a well-equipped 33-bed hospital. This beautiful community offers outstanding outdoor recreation. For more information contact Laurie Fuller: 604 485-3927, email: clinic@tmca-pr.ca, website: powellrivermedicalclinic.ca.

SOUTH SURREY/WHITE ROCK—FP
Busy family/walk-in practice in South Surrey requires GP to build family practice. The community is growing rapidly and there is great need for family physicians. Close to beaches and recreational areas of Metro Vancouver. OSCAR EMR, nurses/MOAs on all shifts. CDM support available. Competitive split. Please contact Carol at Peninsulamedical@live.com or 604 916-2050.

SURREY (GATEWAY PRIMARY CARE CLINIC)—GPS, LOCUM & PART-TIME
The Gateway Primary Care Clinic is looking for a part-time locum (1 day/week in February; 2 days/week from March to September 2020) as well as part-time GPs (1 day/week) to join our team. The clinic, conveniently located at the Gateway Skytrain station, provides medical care to individuals experiencing mental health and substance use issues, and their families. The clinic staff includes GPs with special interest in mental health and substance use, family NP, RNs, and MOAs. We use a team approach to service delivery through coordination of care with mental health and addictions, hospital, and other community agents. Remuneration is two sessions per day. Contact loretta.kane@fraserhealth.ca.

SURREY/DELTA/ABBOTSFORD—GPS/SPECIALISTS
Considering a change of practice style or location? Or selling your practice? Group of seven locations has opportunities for family, walk-in, or specialists. Full-time, part-time, or locum doctors guaranteed to be busy. We provide administrative support. Paul Foster, 604 572-4558 or pfoster@denninghealth.ca.

VANCOUVER/RICHMOND—FP/SPECIALIST
The South Vancouver Medical Clinic seeks family physicians and specialists. Split is up to 80/20. Closing your practice? Want to work part-time? Join us to see only booked patients or add walk-ins for variety. Oscar EMR. Positions in Richmond also available. Contact Dr Balint Budai at tgr604@gmail.com.

VICTORIA—FULL/PART-TIME FAMILY PHYSICIAN
Option to bring your own practice or for long-term locum. Our office is bright, friendly, and well run with low shared expenses. We value work-life balance. Work in the most beautiful place on earth. Contact Narissa Arter, office manager, phone: 250 478-2133, email: naarter@gmail.com.

VICTORIA—GP/WALK-IN
Shifts available at three beautiful, busy clinics: Burnside (www.burnsideclinic.ca), Tillicum (www.tillicummedicalclinic.ca), and Uptown (www.uptownmedicalclinic.ca). Regular and occasional walk-in shifts available. FT/PT GP post also available. Contact drianbridger@gmail.com.

MEDICAL OFFICE SPACE

MAPLE RIDGE—MEDICAL OFFICE SPACE FOR LEASE
Turnkey opportunity to establish or relocate your practice. Brand new medical offices in a three-story, state-of-the-art, new professional medical building in Maple Ridge. Custom-made reception area, free parking on site, staff room, six to eight exam/office rooms in each clinic, bright and spacious, private washrooms, security surveillance with enterphone for private access. Steps away from downtown Maple Ridge. Near the local hospital. Life Lab and pharmacy nearby. Very attractive and competitive rate. Contact

Ross: 778 688-7453 or email medkineticmedicalsupplies@gmail.com.

NORTH VAN—MED OFFICE SPACE ACROSS FROM LIONS GATE HOSP
Bright, south-facing, fully finished 600 sq. ft. office space. Ideal for one or two physicians. Underground parking available. Very short walk to Lions Gate Hospital, Whole Foods, pharmacy, and diagnostic imaging. Available February/March 2020. If interested call 604 375-0692 or email Lotusland855@gmail.com.

SALT SPRING ISLAND—EXECUTIVE HOME AND PROFESSIONAL OFFICE
Executive home and professional office: 3190 sq. ft., four bedrooms, three baths, extensive gardens, separate garage/workshop, sauna, two decks, good access, off-street parking, centrally located, detailed brochure available, contact owner at 250 931-7785, $820 000. Video: https://youtu.be/S3lhpx6aSrM.

SOUTH SURREY—MED OFFICE SPACE
Flexible workspace available in a new clinic in South Surrey designed specifically for health care practitioners. West Coast Neuro Health Clinic offers fully furnished, IT-enabled workspace from half-day sessional rates to full-time long-term leases. Rates vary from office-only to fully serviced, including receptionist, cloud based EMR (Accuro), scheduling appointments, appointment reminders, refreshments, and online forms for patients prior to appointment. Free parking for staff and patients. For enquiries, please contact Juan Patuel, 604 560-8811, juan@westcoasthealth.ca. Website: www.westcoasthealth.ca.

VANCOUVER (BROADWAY CORRIDOR)—OFFICE FOR SALE
Broadway Medical (943 W Broadway). Spectacular North Shore view, turnkey, 650 sq. ft. seventh-floor office with three exam rooms and one office (one exam room and office with mountain view), waiting area, and reception area with two built-in desks. Lots of storage space. Office designed by Richard Salter. Ideal for two physicians: pediatrician, family physician, or specialist. Contact gaildodekwenner@gmail.com.

VANCOUVER—IDEAL PSYCHIATRIST/PSYCHOTHERAPIST OFFICE SPACE
West Point Grey office space available 1 January (date flexible) for rent full-time or part-time. Ideal for psychiatrist/psychotherapist. Bright, spacious, mountain view, very reasonable rent. Shared common waiting room, no secretary, designated doctor parking, easy transit access. Email jclaman@mail.ubc.ca or marish@telus.net for further details.

VANCOUVER—NEW MED OFFICE SPACE IN KITS
New medical office space available at 2667 West Broadway as of 1 May 2020. Space shared with a three-physician family practice (not walk-in) with experienced MOA support. Please contact kitsfamilypractice@gmail.com if interested.

VACATION PROPERTIES

PROVENCE, FRANCE—YOUR VILLA
Les Geraniums, a luxury 3-bedroom, 2½ bath villa, is your home in the heart of Provence. Expansive terrace with pool and panoramic views. Walk to lovely market town. One hour to Aix and Nice, 45 minutes to Mediterranean coast. Come and enjoy the sun of southern France! 604 522-5196. villavar835@gmail.com.

MISCELLANEOUS

CANADA-WIDE—MED TRANSCRIPTION
Medical transcription specialists since 2002, Canada wide. Excellent quality and turnaround. All specialties, family practice, and IME reports. Telephone or digital recorder. Fully confidential, PIPEDA compliant. Dictation tips at www.2ascribe.com/tips. Contact us at www.2ascribe.com, info@2ascribe.com, or toll free at 1 866 503-4003.

FREE MEDICAL RECORD STORAGE
Retiring, moving, or closing your family practice? RSRS is Canada's #1 and only physician-managed paper and EMR medical records storage company. Since 1997. No hidden costs. Call for your free practice closure package: everything you need to plan your practice closure. Phone 1 866 348-8308 (ext. 2), email info@rsrs.com, or visit www.RSRS.com.

PATIENT RECORD STORAGE—FREE
Retiring, moving, or closing your family or general practice, physician's estate? DOCUdavit Medical Solutions provides free storage for your active paper or electronic patient records with no hidden costs, including a patient mailing and doctor's web page. Contact Sid Soil at DOCUdavit Solutions today at 1 888 781-9083, ext. 105, or email ssoil@docudavit.com. We also provide great rates for closing specialists.

VANCOUVER—OFFICE EQUIPMENT FOR SALE
Suction pump, cautery units, centrifuge, headlights, and many more items including lasers and operating microscopes for sale. Call 604 657-1599 or email geraldboey@hotmail.com for complete list.

VANCOUVER—TAX & ACCOUNTING SERVICES
Rod McNeil, CPA, CGA: Tax, accounting, and business solutions for medical and health professionals (corporate and personal). Specializing in health professionals for the past 11 years, and the tax and financial issues facing them at various career and professional stages. The tax area is complex, and practitioners are often not aware of solutions available to them and which avenues to take. My goal is to help you navigate and keep more of what you earn by minimizing overall tax burdens where possible, while at the same time providing you with personalized service.
Website: www.rwmcga.com, email: rodney@rwmcga.com, phone: 778 552-0229.

Club MD

PUT YOURSELF IN THE PICTURE.

Exclusive deals from brands you trust

You work hard. Your downtime is important and we want to help you make the most of it to do the things you love. Club MD provides exclusive deals from trusted brands so you can spend your time on what's important.

CAR PURCHASE & LEASE • ENTERTAINMENT • FITNESS & WELLNESS • FOOD & BEVERAGE • HOTELS & TRAVEL

COAST HOTELS

PREFERRED RATES FOR DOCTORS OF BC MEMBERS

doctorsof**bc**.ca/coast

Exceptional value and friendly service, there's no place like Coast!

Call 1 800 716 6199 or book online with company ID: CLUBMD, Doctors of BC.

DUECK GM

VEHICLES PRICED AT **DEALER'S COST PLUS 3.5%**

doctorsof**bc**.ca/dueck

Excellent selection of new and pre-owned vehicles.

Call 604 324 7222 or email david.kent@dueckgm.com and quote promo code DOCTORSOFBC.

THE MORTGAGE GROUP

EXCLUSIVE RATES AND TERMS

doctorsof**bc**.ca/tmg

Experts at finding the right solution to fit your financial needs.

Call 604 351 1569 or email rweber@mortgagegrp.com and mention Club MD.

P 604 638 7921
TF 1 800 665 2262 ext 7921
E clubmd@**doctors**of**bc**.ca

doctorsof**bc**.ca/club-md

doctors of bc

Help families team up against ANXIETY

Confident Parents: Thriving Kids - Anxiety is a free program helping BC families overcome anxiety challenges in children ages 3–12.

This web- and phone-based coaching service helps parents and caregivers learn effective skills and strategies for managing anxiety. It's available by referral from physicians, clinicians and pediatricians.

Download referral forms at
confidentparents.ca

Canadian Mental Health Association
British Columbia
Mental health for all