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.

Aphantasia

"If counting sheep is an abstract concept to you, or you are unable to visualize the faces of loved ones, you could have aphantasia."[1] The origin of the word is "a" from the English "without" and the Greek "phantasia" meaning imagination or appearance.

The phenomenon was first described by Francis Galton in 1880 and remained relatively unknown until publication of a study conducted by a team led by Professor Adam Zeman of the University of Exeter. Hyperphantasia, the condition of having extremely vivid mental imagery, is the opposite of aphantasia. In a research report by Professor Zeman published in 2020, he describes hyper vivid visual imagery as allowing one to inspect absent items in the mind's eye, somewhat as if one was seeing them.[2]

My experience with aphantasia began with a report by the BBC of the condition described above. I was a practising anesthesiologist who retired in 2018 and realized that the description of aphantasia applied to me. I subsequently took a number of tests online under the heading of Vividness of Visual Imagery Questionnaire (VVIQ), which confirmed my poor visual imagination.

During my career in anesthesia, I made extensive use of atlases to aid me in the performance of regional anesthesia such as spinal and epidural anesthetics. Although moderately proficient in such techniques, I would often call on colleagues when I had an especially challenging patient with obesity. In particular, one colleague who would reliably be successful in cases where I struggled had what I thought of as X-ray vision.

I write this short report to bring awareness of this condition to the general medical community, especially in areas where visualization may play an important role. Diagnosis of this condition is initially established by the VVIQ, which I mention above. Establishing this condition in medical students may help learning in areas where visualization is important and also in specialty selection. Finally, there are many resources on the Internet to explore this condition.

—Thomas M. D'Arcy, LRCP&SI, FRCPC
Vancouver

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1. University of Exeter. Can't count sheep? You could have aphantasia: Some people are born without the ability to visualize images. ScienceDaily, 26 August 2015. Accessed 25 September 2021. www.sciencedaily.com/releases/2015/08/150826101648.htm.
2. Zeman A, Milton F, Della Salla S, et al. Phantasia–The psychological significance of lifelong visual imagery vividness extremes. Cortex 2020;130:426-440.

Re: Re-embracing physical activity after COVID-19

Recommending that patients exercise more is definitely a worthwhile venture, as Dr Anne Pousette outlined in her article, "Re-embracing physical activity after COVID-19: What is the physician's role" [*BCMJ* 2021:63:298]. In fact, she says, "Physicians can play a crucial role in promoting a societal return to physical activity." But by recommending that family physicians take on this task, and giving time-consuming examples of how they might do that, I am wondering if Dr Pousette is aware of what province she practises in.

BC MSP does not allow family physicians, or any physicians, to bill MSP for such counseling or for any lifestyle or preventive counseling. This is clearly outlined in the Doctors of BC revised fees for uninsured services document (www.doctorsofbc.ca/sites/default/files/uninsured_services1apr2021_421287.pdf). Patients are to be billed under code A00054, which states: "Preventative medicine counselling all forms, e.g.: health maintenance, assessment and counselling to include physical examination, smoking withdrawal and other harmful habits, weight and/or diet control, exercise programs (planning and management), stress management techniques, social support systems, establishing normal sleep patterns and other forms of lifestyle counselling - per half hour $158.00."

Dr Pousette's recommendations clearly fall under the above uninsured fee code, meaning MSP cannot be billed for such a visit. That means family doctors are left with the impossible choice of either doing the work and not being paid, which is clearly untenable, or saying sorry to patients who want advice for weight loss, smoking cessation, or exercise guidelines. Please, Doctors of BC, consider requesting coverage of such services in your next round of fee negotiations. Our patients, our families, our communities deserve it.

—Lesley Horton, MD, CCFP
Vancouver

Author replies

I will leave responding to the issue of billing in relation to "lifestyle or preventive counseling" to those engaged in prioritizing health system spending. However, I would like to acknowledge that those are important conversations, particularly given the inequity of health and outcomes that have been exemplified throughout the pandemic and reported extensively elsewhere. Thank you, Dr Horton, for placing the topic back on the table for discussion.

When this article was written and the core messages conceived, we anticipated that by November 2021 much of COVID-19 would be in the rearview mirror. We anticipated looking forward—addressing what we learned from the pandemic about health inequities and

re-engaging in proactive use of health promotion knowledge and evidence. Sadly, we are still facing the strain of a fourth wave.

The capacity of family physicians to engage in these conversations is recognizably dependent on their practice contexts, their community resources, and their own comfort with and knowledge of the topic. The suggestions offered in the article were provided in response to requests from physicians for specific information that would assist them in promoting physical activity to whatever extent is feasible in their roles as physicians. There was no intent to add burden to physicians who already have a full plate, but rather to enhance opportunities for physicians to be part of a large cross-sectoral strategy to enable British Columbians from all walks of life, across the life course, to benefit from health-enhancing physical activity.

The province of BC's comprehensive physical activity strategy, Active People, Active Places,[1] and the 2020 update[2] documents provide a framework for collective action by multiple stakeholders. Physicians belong at the implementation table and have much to offer at multiple levels—from what happens in our offices to advocating for policy and spending priorities. Collectively, we can make a difference, just as we have in the areas of seatbelts, helmets, and smoking cessation.

—Anne Pousette, MD, MPH
Council on Health Promotion

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1. Province of British Columbia. Active people, active places – British Columbia physical activity strategy. November 2015. Accessed 12 November 2021. www.health.gov.bc.ca/library/publications/year/2015/active-people-active-places-web-2015.pdf.
2. Province of British Columbia. Active people, active places – British Columbia physical activity strategy. 2020 update report. Accessed 12 November 2021. www2.gov.bc.ca/assets/gov/health/managing-your-health/physical-activity/active-people-active-places-2020-status-update-report.pdf.

BC Family Doctors replies

BC Family Doctors was asked to provide a response to Dr Horton's letter regarding the article "Re-embracing physical activity after COVID-19: What is the physician's role?" The article highlighted the critical role that family physicians play in promoting a return to physical activity and other health promotion activities. Dr Horton correctly pointed out, however, that this care, as with many health promotion activities, is currently not payable by MSP as an insured service.

This discussion highlights a disconnect between the practice of medicine and the current fee-for-service system in BC. Under the General Preamble of the MSC Payment Schedule,[1] the fees are for "services which are medically required for the diagnosis and/or treatment of a patient." The Preamble further states that, "when services are provided for simple education alone. . . such services are not appropriately claimed under fee-for-service listings." As a result, the uninsured fee A00054 exists in the Doctors of BC Fee Guide for Uninsured Services[2] to enable private billing for preventive medicine counseling of all forms.

Community-based longitudinal family physicians can bill chronic disease management[3] fees for providing guideline-informed care, including encouragement of physical activity, for patients with specific health conditions (diabetes, hypertension, COPD, and congestive heart failure). Similarly, this small cohort of physicians can also provide personal health risk assessment[4] visits with at-risk patients, including patients with physical inactivity. However, this fee is limited to 100 patients per calendar year per physician.

These fee code limitations make it almost impossible to provide primary care that is inclusive of health promotion activities recommended by Doctors of BC's Council on Health Promotion. The current Payment Schedule is a complex, antiquated document that does not reflect modern medical practice or support patient-centred appropriate care. Despite the agreed-upon direction for primary care transformation,[5] family physicians have limited ability to provide comprehensive, equitable, high-quality care due to current fee-code constraints.

BC Family Doctors believes that we need to modernize and create equity in physician compensation.[6] This requires a comprehensive review of the MSC Payment Schedule, including updating the General Preamble. Together with the introduction of alternate payment models, fee-for-service modernization will align current medical practice with the values and goals of our health care system. As we emerge from the pandemic, we need to consider how we build a stronger, more equitable health care system that meets the needs of all British Columbians.

—Renee Fernandez, MD, CCFP
Executive Director, BC Family Doctors

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Re: Canada's largest purpose-built public day-care surgery centre

The conclusions in this article [*BCMJ* 2021;63:330-335] are predicated on two observations—that the admission rate for outpatient surgery is very low and that the readmission rate is also very low. What the study does not address is a reasonable explanation for the difference in admission rates for outpatient surgery in the setting of a hospital and that of a same-day surgery centre. What am I missing? I suspect there is a strong bias at play.

—Scott A. Lang, MD
Calgary, AB

Author replies

I agree that there is a strong bias in play in hospitals to admit a patient rather than discharge them. The ease of bed access and the ingrained habit of admitting that is present

at a full-service hospital is not present at an outpatient centre.

Our article clearly shows a low rate of unplanned admissions and readmissions in patients who receive their surgery at the Jim Pattison Outpatient Clinic and Surgery Centre (JPOCSC). As mentioned in the article, our criteria for eligibility for surgery at this centre are clearly defined (ASA 1 or 2 and no history of significant sleep apnea or adverse reactions to general anesthetic). When all variables are controlled, the admission rate at a hospital is significantly higher than at an outpatient centre.

In a previous article looking at the unplanned admission rate in breast reconstruction patients at JPOCSC and Surrey Memorial Hospital, a significant difference in admission rates was observed when all other patient variables were controlled for.[1] The surgeons and anesthetists are the same individuals at both sites; therefore, the only remaining explanation is an institutional bias to admit. As the OR theatre staff is the same, this bias lies in the postanesthetic care units and day surgery units present in full-service hospitals. It is this inherent bias that our article hopes to change, showing that discharge rates for planned day-care surgeries can be very high, and that planned outpatient surgery centres cannot have a bias to admit.

—Paul Oxley, MD, FRCSC
Surrey

Reference

1. Oxley PJ, McNeely C, Janzen R, et al. Successful same day discharge after immediate post-mastectomy alloplastic breast reconstruction: A single tertiary centre retrospective audit. J Plast Reconstr Aesthet Surg 2020;73:1068-1074.

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Temporary fee codes for 2021/22 flu season

As of 1 October 2021, temporary fee codes introduced last year for adult influenza and pneumococcal immunizations have been reactivated for the 2021/22 flu season. The reactivation was made to address the increased costs of providing immunizations during COVID-19.

In addition, pertussis immunization in pregnancy has been added to the list of immunizations for which these fee codes can be billed. This has been a publicly funded vaccination in BC since November 2020.

Both temporary respiratory immunization fee codes are effective for dates of service on or after 1 October 2021, with an end date of 30 April 2022.

Details of the fee

T10040 Respiratory immunization for patients 19 years of age or older (with visit):

- Payable for influenza (using ICD-9 code V048) and pneumococcal (using ICD-9 code V05) and pertussis during pregnancy (using ICD-9 code V036) immunizations.
- Payable in full with an office visit.
- If the primary purpose of the service is for immunization, bill fee item 10041 using ICD-9 code V048 for influenza, and/or V05 for pneumococcal and/or V036 for pertussis during pregnancy.

TB10041 Respiratory immunization for patients 19 years of age or older (without visit):

- Payable for influenza (using ICD-9 code V048) and pneumococcal (using ICD-9 code V05) and pertussis during pregnancy (using ICD-9 code V036) immunizations when the primary purpose of the service is for immunization.
- Not payable with an office visit.

#BePelvicHealthAware: Starting conversations about pelvic health

One of every two women will experience one or more pelvic floor symptoms during her lifetime. Led by Dr Roxana Geoffrion, urogynecologist and UBC researcher, a Vancouver-based team launched www.bepelvichealthaware.ca and an accompanying social media campaign to promote pelvic floor health by sharing best practices. The website is home to four whiteboard animation videos, with more to come. Through simple images and plain language, the videos aim to illustrate best practice clinical guidelines on pelvic health and prevention of disease from the Society of Obstetricians and Gynecologists of Canada.

So far, the videos cover pelvic health and pregnancy, obstetrical anal sphincter injuries, pessaries, and urinary incontinence. The website also offers information on pelvic health after childbirth, menopause-related issues, pelvic floor disorders such as prolapse or incontinence, and the importance of exercise to keep healthy. Website viewers are also encouraged to submit their own questions. The goal is to provide access to medical information on these sensitive topics and empower people to speak to their providers about childbirth trauma, healing, and prevention of further disease.

The website and its resources are also aimed at women's health care providers looking to direct their patients to simple evidence-based information on pelvic floor health during pregnancy and beyond.

To learn more about the campaign, visit www.bepelvichealthaware.ca or follow the team on Instagram or Facebook. Visit www.bepelvichealthaware.ca/spread-the-word for a communications toolkit with sample web and social media content to share with patients.