All in 40 years' work: Differences of opinion

We owe almost all of our knowledge not to those who have agreed but to those that have differed.
—Charles Colton, 1825

Following a substantive review by the Doctors of BC's Governance Committee, and a report and decision by the Doctors of BC Board, it was announced in January that the subcommittees of the Council on Health Promotion (COHP), including the Emergency and Public Safety Committee (EPSC), will be discontinued in late 2021. The present initiatives and responsibilities of these subcommittees will be refocused into special project groups under COHP. The structure and operational functioning of these groups remains to be determined. We would like to look back on the many initiatives that have been brought forward by the EPSC, previously known as the Emergency Medical Services Committee (EMSC), over its more than 40 years.

From personal recollection, we believe the EMSC has been in existence since at least the 1970s. In the mid-1980s it became a subcommittee of COHP. It has acted as a voice for BC's physicians on matters of vehicle safety (including alcohol and drug impairment and medical fitness to drive), disaster preparedness, prehospital and trauma care, and opioid overdose prevention services, as well as other special subject areas it has been tasked to address. Over previous decades the subcommittee has established an excellent and constructive working relationship with RoadSafetyBC (previously the Office of the Superintendent of Motor Vehicles), to the benefit of all.

However, the road traveled was not always smooth. There were bumps along the way with various opposing advocacy groups, municipal and provincial governments, and within the association itself. Many programs that originated from the EPSC/EMSC are now taken for granted and proudly referenced. Examples are the introduction of mandatory seatbelts in vehicles, bicycle helmet requirements, excessive-speeding restrictions, impaired driving standards, banning of cellphone-distracted driving, and disaster preparedness at all levels.

Voices calling for change will always originate as dissenting voices.

That there was vocal opposition to some of this, including from BCMA members and Board appointees, should not be surprising. We observe that nearly all positive public health advances, since the 1854 destruction of Broad Street's cholera-producing pump, have been initially unpopular with the public, the media of the day, and frequently, the medical profession itself. A candid review of the BCMA/Doctors of BC history would confirm this.

Health advocacy can be controversial and polarizing. Nevertheless, without these healthy internal organizational frictions between zealous physician advocates and eager groups armed with sound scientific evidence to challenge established norms and opinions, little physician-driven health advocacy and social change would have occurred. We believe it is safe to say that the province's physicians would not presently enjoy their high level of public trust without these lively internal debates and the decisions to move forward.

The authors are both old enough to recall when an education meeting was held the day before each June BCMA AGM. Afternoon presentations from COHP offered an opportunity for members to make health promotion resolutions from the floor. That is how the initiative for bicycle helmets began in 1986. Board member attendance at this portion of the meeting was regrettably low. COHP subcommittees were invited to submit resolutions to be considered by the BC caucus for presentation at each August CMA General Council. There were robust discussions in a special caucus meeting in the month ahead. Caucus members were assigned mover and seconder roles, expected to research and present the motion succinctly (preferably with a bilingual component), and everyone took part in setting priorities.

The CMA disbanded its Health Promotion Committee 6 years ago. After 2017, the BC caucus became much smaller and no longer invited COHP resolutions to convey to the CMA, as the CMA changed its process of receiving policy submissions. Many past CMA policy resolutions originated from the BCMA. Some of these were endorsed and formed national policy, such as the restricted use of hands-free cellular phones, random breath testing, and calls for improvements in hospital disaster preparedness. Other COHP subcommittees and chairs have successfully lobbied for policies to

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Enhancing care for patients with a history of trauma

A list of books and articles about trauma-informed care, available through the College Library, is provided online at www.cpsbc.ca/files/pdf/Library-Trauma-Informed-Care-Resources.pdf. The books and articles were selected with particular focus on those providing practical recommendations to optimize care for patients who have experienced a traumatic event.

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.*

People who have experienced traumatic events may find the health care environment particularly challenging, but they are also at greater risk of having health problems.[1] These resources can assist with the multiple challenges of initiating communication, building trust, and addressing individual needs.[2,3]

Electronic resources are listed first. Physical books are available for loan and are delivered via Canada Post with free return postage included.

If you would like a list of articles on a specific aspect of trauma-informed care, such as its implementation in a particular setting, or specific to a particular type of trauma, request a literature search via this online form: www.cpsbc.ca/literature-search-requests. ■

—Niki Baumann
Librarian

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restrict tobacco advertising (Bill C-51), pursued improved nutrition standards, promoted improved health through physical activity, and addressed the issues of healthy aging and preventing frailty.

Voices calling for change will always originate as dissenting voices. Constructive avenues for transformation must remain open in any organization or it risks having change forced upon it. We trust that any new health advocacy configuration, and the projects that evolve from COHP, will ensure sufficient member and subject-expert participation, and that the kinds of successful initiatives of the COHP's previous subcommittees will lead to further advancements and healthy societal change. ■

—Chris Rumball, MD

—Ian Gillespie, MD