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.

Compliments to the artist

The April issue's cover image is credited to Jerry Wong (Peaceful Warrior Arts). I want to pay a compliment as this is truly one of the best and most inspired covers I can recall. It truly illustrates the story on ectopic pregnancy. I hope it is entered into some contest, as it's a real winner!

—Paul Thiessen, MD, FRCPC
Vancouver

Value of family physicians

Yesterday we were in need of a professional gas fitter to make a house call to fix a problem with a gas line in our home. It was a simple problem for him, requiring about 10 minutes. His fee was $156 plus tax for a basic house call. I contrast that with a basic house call that I make as a physician. The last time I looked, the fee was about $110. I am thankful that none of my five children have chosen family medicine as a career. They are all in technical trades or engineering. It is interesting that I am to conclude that the services of a gas fitter are about 50% more valuable to society than the services of a family physician based on the fees paid to these two respective professions.

—Robert H. Brown, MD, CCFP
North Saanich

Re: Lost art of physical examination

I really appreciated Dr Walton's germane reflection on the role the physical examination seems to play in patient assessment these days [*BCMJ* 2021;63:102]. I'm one of those Neanderthal retired family docs who practised before CT scans, MRIs, and other magical technologies.

An acute appendix was first on a differential diagnosis as the result of history and specific physical examination. It was okay to then proceed to the OR, recognizing that it might rarely end as an exploratory event. It's now quite kosher to listen to breath and heart sounds through clothing—it's happened to me, by a fine young physician. The world moves on, but practising the fine points of physical diagnosis need not be a dying art.

—Neil Finnie, MD
Victoria

Re: The gender pay gap in medicine

Thank you, Dr Sin, for your April editorial on this important topic [*BCMJ* 2021;63:101]. Studies show that women also have increased rates of burnout compared with male colleagues. The pandemic has had an extra toll on women, making all of this much worse.

You point out that there are some clear recommendations that have been made to work to close this gap. We know this is a complex issue that will take many nuanced changes, but a few broad strokes can happen now. Encouraging men to take parental leave is a wonderfully achievable place to start, and is evidence-informed. Maybe we will see Doctors of BC promote this more widely. Doctors of BC could also be targeting and measuring its success in having women in leadership roles, and being transparent about what percentage of stipends goes to men versus women might be an enlightening project. The kind of encouragement needed for women to be in the places where decisions are made is often structural. This is not phoning, emailing, and telling them they would be great and should apply—not that kind of encouragement. We are talking about changing how we recruit, support, and retain women in leadership by making gender equity a priority through tangible goals, metrics, and system improvements. This is negotiation time for the PMA and gender equity could be a value that is baked into the process. Imagine what we might achieve if this were the case!

I am excited that you have opened up this conversation in a meaningful way for Doctors of BC and all of us in the province. I look forward to reading more articles on what we are doing and how well we are making progress to reduce the gender pay gap. Thanks for taking this brave step, since we know you are likely to experience significant backlash as a result of speaking out for gender equity.

—Brenda Hardie, MD
North Vancouver

I appreciate Dr Sin's call to action in her April editorial [*BCMJ* 2021;63:101]: "Ultimately, the question we should each be asking ourselves is not whether a gender pay gap exists in medicine, but what can I do to help close it?" And I urge our professional representative body (Doctors of BC) and our main payer (BC Ministry of Health) to (1) engage experts to do a review of processes and structures that are maintaining the gender pay gap, despite intentions to have it change, and (2) start to publicly report what this examination finds.

—Rita K. McCracken, MD, PhD, CCFP (COE), FCFP
Vancouver

Re: On the nature of being a professional

Bravo, Dr Chow! I'm retired from practice now after 50 years as a GP/FP and found your article in the April issue to be a breath of fresh air [*BCMJ* 2021;63:105]. The profession is facing decreasing numbers of physicians. Physician burnout has become a byword. Physicians are losing the esteem from their patients, while other health care professionals are enjoying increasing popularity from their patients and clients. To be a physician was once to also be a trusted member of a patient's and their family members' special circle, trusted as a caring friend, but alas, the pressures of practice, bureaucracy, paperwork, and rules of conduct have disenfranchised us from the art of medicine, often creating a seemingly adversarial relationship with those we care for. Your philosophy of medical practice illustrates a means to bring back the very real joy of being that

caring professional friend to those we care for.

Thank you for the wise encouragement.

—Brian S. Pound, MBBS, LRCP, MRCS, LMCC
Victoria

Re: Managing vulnerable patients

I was interested to read the April 2021 article, "Management of vulnerable adult patients seeking to leave hospital: Understanding and using relevant legislation," having had just such a conundrum during my shift the previous evening. Unfortunately, the article did not specifically address a certain common situation. Any insights from the authors would be much appreciated.

Incapacity due to addiction

By my reading of the article, my patient (whose parents were strongly advocating be involuntarily admitted due to severe and progressive self-neglect as a result of alcoholism) fulfills the criteria to allow treatment under the Adult Guardianship Act (AGA) (1. self-neglect, 2. risks, already experienced—e.g., loss of licence to drunk driving, assault charges etc., and 3. incapacity due to chronic unremitting intoxication).

It is not regular practice to force treatment due to addictions. This patient was kept under the Health Care (Consent) and Care Facility (Admission) Act until sober enough to ambulate safely and have a discussion regarding his situation, at which point he could voluntarily continue treatment or leave against medical advice.

Is this sober window (reportedly the only such window in a very long time) enough to allow the patient to voluntarily proceed back into his state of chronic alcohol-induced incapacity (not withstanding that the illness of addiction renders the patient incapable of avoiding further intoxication)? If it is not, should we be using the AGA routinely in cases of addicted vulnerable adults?

Also, the fictional case of Ms Safe was a useful illustration. I imagine the statement that she'd "be fine" was explored in more detail. What if she'd meant: (1) I'll be fine because I wish to die from this illness, or (2) I understand the risks you're telling me but I'll be fine with the natural medicines I'm using, or my faith that God will heal me?

—Roger Seldon, MBChB, MD
Campbell River

Authors reply

Regarding use of the Adult Guardianship Act (AGA) for individuals with chronic substance use, it should be clarified that the Act allows involuntary admission in hospital to investigate whether a person meets full criteria for Section 59. Section 59 allows ongoing hospitalization until a support and assistance plan can be put in place to try to mitigate the risks of, in your example, self-neglect. The first criterion of the AGA is that the adult is unable to seek support and assistance when needed.[1] Such assessments are conducted by a designated responder, typically a social worker, once an individual is no longer intoxicated. Assessments for AGA eligibility will often incorporate information or assessments from other disciplines, such as occupational therapy, psychiatry, or geriatric medicine to assess for factors that increase vulnerability while not intoxicated, such as neurocognitive disorders. For many individuals without baseline cognitive impairment, the patient will demonstrate an ability to seek support and assistance when not under the influence of substances, rendering them ineligible for Section 59. However, if a patient shows that they are unable to seek support and assistance even once they are no longer intoxicated, for example because of a neurocognitive disorder secondary to alcohol use, they may meet the criteria for Section 59 if the other criteria are also satisfied, as outlined in Figure 1 of our article.[2]

Thought must also be given to how using a support and assistance plan can modify the identified risks of using substances, recognizing that we cannot typically force individuals to abstain from substances alone. Exceptions to this do occur, rarely, for individuals with significant vulnerabilities; for example, a neurocognitive disorder rendering them at risk of regular and significant substance abuse causing self-neglect. However, these cases typically exist after less intrusive measures have failed and are likely to involve a court-ordered support and assistance plan that restricts an individual's access to substances due to residing in a care facility.

Regarding the issue of "alcohol-induced incapacity," it is important to answer the question, capacity for what kind of decision? It is certainly reasonable to question an individual's capacity to make decisions about how they live their life when they are living at significant risk. For example, does the patient have capacity to make decisions about being homeless, or using substances? However, housing or substance use are not medical treatments and, therefore, don't fall under the Health Care (Consent) and Care Facility (Admission) Act. Therefore, saying that an individual is incapable of making decisions regarding substance use or housing does not permit us to take any action in the way of appointing a substitute decision maker as we would for medical treatment. Furthermore, even if someone fails to see the negative foreseeable consequences of their substance use,

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which suggests incapacity, existing legislation does not address forcing individuals to abstain from substances alone if they are incapable of making a decision to use them. Instead, it is best to focus on whether an individual meets criteria for the AGA, or in some cases, the Mental Health Act.

Regarding the case of Ms Safe, she had communicated that she thought her health would remain unchanged or stable without IV antibiotics. Therefore, Ms Safe failed to appreciate the foreseeable negative consequences and risk of death if she refused treatment, rendering her incapable of making a decision to decline medical treatment. In reply to another of your examples, such as if the patient said she wished to die from her illness, that suggests she understands the foreseeable consequences of declining treatment, which is one of several important criteria of capacity. In our experience, that kind of response could signal a potential desire for hastened death, which would trigger a psychiatric consult to rule out an underlying mood disorder. For the other examples, capable patients may have spiritual beliefs or preferences for nonconventional treatments. The test of capacity would be whether the patient understands the nature and anticipated effects of the proposed investigation or treatment and available alternatives, including the consequences of refusing.[3,4]

—Jennifer Laidlaw, MD, FRCPC

—Leanne Lange, MPA

—Erin Henthorne, MSW, RSW

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News

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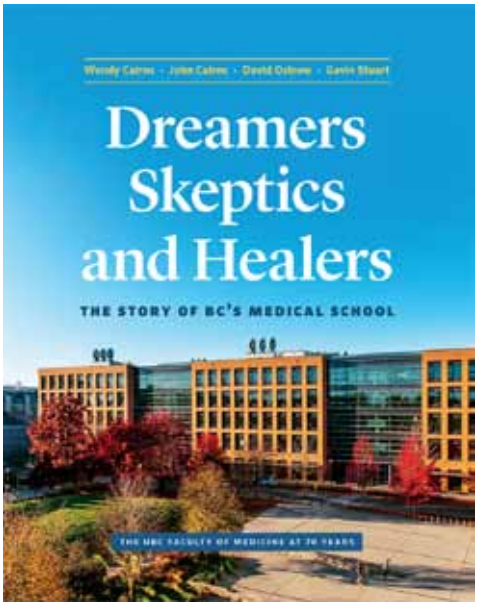

Book review: *Dreamers, Skeptics, and Healers: The story of BC's medical school*

By Wendy Cairns; John Cairns, MD; David Ostrow, MD; Gavin Stuart, MD. Vancouver: Page Two Books, 2021. ISBN 978-1-989603-89-5. Hardcover, 224 pages.

The mastermind behind this history of UBC Medical School was UBC graduate Wendy Elizabeth Cairns. After her premature death in 2018, her husband and former dean of the medical school, Dr John Cairns, along with Dr David Ostrow and Dr Gavin Stuart, took up the pen to expand on and complete the process of turning Wendy's rich research materials into this book. The title, *Dreamers, Skeptics, and Healers,* accurately reflects the history of a medical school that admitted its first class in 1950 after years of controversy and is now counted among the largest and most respected medical schools in North America.

I arrived in Vancouver in 1947 as an 18-year-old immigrant, full of hope that I might be able to enter medical school here. I learned with considerable anxiety that there was no medical school in BC, and that the likelihood of one opening soon was not very good. Only 4 years later, I was in UBC Medicine's second graduating class of 60 students, when the school was still located in former army barracks. Skeptics were abundant from before the school opened and throughout its early years; it was the dedicated deans, scientists, and healing practitioners who brought the dreams to reality.

This very handsome, easy-to-read book includes wonderful pictures of many of the doctors, healers, scientists, and administrators who made the school what it is today. The book is divided into seven parts. It starts with Dr John Sebastian Helmke's ideas for a health service, for a then fledgling population, in the 1870s. And it ends with a proud celebration of the research and innovation that has taken place over the past 70 years, with ideas for the future.

In between are accounts of how the school took off after years of arguments and disappointments, the unavoidable growing pains, and how it came into a respected early maturity, with some unexpected turnarounds, to become a world famous medical school (the Faculty of Medicine is now home to more than 4500 undergraduate, graduate, and postgraduate students), with students learning the art and science of medicine in almost every district of BC.

I had the feeling of reliving my student days as I read the sections on how Dr Kerr and Dr Walters conducted our oral exams at the bedside, how Dr Friedman, the head and professor of anatomy drew his diagrams on the blackboard with two hands at the same