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.

Where have all the family doctors gone?

Try to find a family doctor in BC and you will be sadly disappointed. Patients are now asking any specialist they see to help them with general medical issues, but specialists have neither the time nor the training to help. Nurse practitioners have a completely different skill set; they are not equipped to take over the role of a family physician. Where are the family doctors we were promised in the "A GP for Me" initiative? It hasn't happened.

The following are but a few examples of the problem.

Linda Swain from Malahat wrote to the *Times Colonist* about access to urgent and primary care centres:

"Each UPCC is geographically based. To even apply to become a patient, two pieces of ID are required to prove residency within the established boundaries of each UPCC. And if the Westshore UPCC is anything to go by, this taxpayer-funded system is a dismal failure. I needed an X-ray requisition and dutifully arrived at 7:15 a.m. and lined up with 20 other people to wait for the 8 a.m. opening, only to be told at 8 a.m. that the facility was 'at capacity' because only one doctor had shown up for work that day! How can a sick person get the care they need when no one seems to care?"[1]

Since Swain wrote this letter, three more clinics in Victoria have closed. My own family physician, Dr G. Zabakolas, an excellent doctor, has quit.[2]

Consider a 93-year-old friend of mine who signed up to become a patient of the James Bay Urgent and Primary Care Centre 2 years ago. She still has no family physician. She never received an intake call.

Consider a young man who injured his neck and back in a motor vehicle accident. He waited at walk-in clinics and looked on Medimap for 4 days. No access. He eventually went to emergency and waited there for hours.

To emergency they go, for minor as well as major health issues. As a result, emergency rooms are overloaded. A Kamloops woman died in the waiting room of Royal Inland Hospital's emergency department last September.[3]

In the past, the health care system worked because family physicians kept patients with minor ailments out of hospital emergency rooms. Serious medical issues were attended to expeditiously. What has happened?

Look no further than physician remuneration. Why do ophthalmologists make $1 000 000 per year and family physicians make $163 000 per year? Most other specialists make over $500 000 per year. Consider that overhead for a family physician's office is 35% to 40% of gross income. Their net income is in the range of less than $100 000.[4]

Where can a family doctor make a better living? As a hospitalist. In the past 10 years, hospitals have been hiring family physicians to take care of complicated patients in the hospital. They are paid $240 000 to $280 000 per year, with no overhead costs. In Victoria, 72 family doctors have recently become hospitalists. In the Fraser Health region that number is 110. The population in Victoria, especially in the western communities, continues to grow but family doctors are getting out of the business as fast as they can.

Other family physicians are leaving practice to become surgical assistants or to practise virtual medicine. Others are taking early retirement or simply quitting from stress.[2]

Some are moving to other provinces. The average remuneration for family doctors in Ontario is $300 000; in Alberta it is $250 000 to $300 000. BC lags far behind.

The first step our government needs to take is to settle the unequal payments physicians receive, and they need to do it now.[5-7] The inequities in the medical funding model need to be addressed.[6] Only our provincial government can do this. The rest of Canada has tackled this problem with some success. BC needs to get on board.

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This letter endorsed by:

Darlene Hammell, MD, CCFP
Past President, College of Physicians and Surgeons of BC
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The current gender-affirming care model in BC is unvalidated and outdated

As a psychiatrist, I have seen an explosion of gender-dysphoric youth and young adults in recent years. These vulnerable groups deserve compassionate, evidence-based care. I am concerned that the recent *BCMJ* content on gender dysphoria presents gender-affirming care as evidence-based[1] and as the *only* appropriate model of care. This premise forms the basis for the three articles that follow on the medicalized treatment of gender dysphoria.

The World Professional Association for Transgender Health (WPATH) Standards of Care Version 7 (SOC7) are not evidence-based. The WPATH website clearly states that SOC8 is the first version being developed using an evidence-based approach. In addition, a systematic review of its clinical practice guidelines states that SOC7 "contains no list of key recommendations or auditable quality standards."[2] Furthermore, "many recommendations are flexible, disconnected from evidence and could not be used by individuals or services to benchmark practice."[2]

Finland, Sweden, Norway, and the UK are re-evaluating care of gender-dysphoric youth due to concerns about medical harm and the uncertainty of benefit.[3]

I find it disconcerting that the validity of SOC7 and the gender-affirming model are wholeheartedly accepted and promoted by these articles. There is no balanced discourse of reported negative outcomes or alternative approaches.

Further, some high-profile members of WPATH have gone on record stating their concerns. Dr Marci Bowers, a trans woman surgeon, publicly disclosed her concerns about puberty blockers, particularly the age at which they are started.[4] Psychologists Drs Laura Edwards-Leeper and Erica Anderson (a trans woman), have raised questions about the significant rise of gender-dysphoric youth, particularly adolescent girls. They have advocated for thorough psychological assessment and questioned the potential harm of not providing exploratory therapy.[5]

While WPATH SOC8 may provide an opportunity for evidence-based guidelines, a review of the draft raises concerns. For example, the section on "eunuchs," presented as a unique gender identity, was bewildering. I question the evidence for this category, and particularly the recommendation to "affirm" and refer for surgical castration lest they attempt self-castration.

For those hesitant to agree, I urge you to watch the Swedish Trans Train documentaries (part 1: https://youtu.be/sJGAoNbHYzk). Canadian physicians should not ignore the potential risks of the affirmation model when there is international evidence of harm to vulnerable youth. Distressed youth deserve diligent, nuanced care favoring psychological assessment and care over medical harm. Concerningly, Bill C-4 (banning conversion therapy) was recently passed by the Senate. Without a clear definition of what constitutes exploratory therapy versus conversion therapy, therapists risk being charged under this bill and may be dissuaded from treating people with gender dysphoria at all.

We are in a unique position to rethink the treatment model for gender dysphoria. I hope we can begin a dialogue, so that our youth can get the treatment they need and deserve. Gender affirmation is not a one-size-fits-all model. To allow ideology to prevail over sound medicine is negligent at best.

—Joanne Sinai, MD, MEd, FRCPC
Victoria

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Re: The value of ancillary testing in amniotic fluid infection/inflammation-related early pregnancy loss and perinatal death in British Columbia

I thank Dr Terry for his informative article [*BCMJ* 2021;63:383-387]. Of the many causes of preterm birth, finding an infectious agent gives hope that treatment might prevent recurrence. However, most bacteria identified during autopsies are commonly found in the lower female genital tract. Their culture from fetal surfaces, lung, and stomach may represent colonization during transit through the maternal vagina rather than pathogenicity. The most common bacteria cultured was Group B *Streptococcus*, a commensal found in the lower genital tract of 20% of women. The second was *E. coli*, which is ubiquitous. Although occasionally pathogenic, sometimes aggressively so, we cannot eradicate either from a woman's gut and vaginal flora for the duration of a future pregnancy. How helpful are these culture results? Do they explain the index preterm birth? Can they help prevent a future one?

Why do commensal organisms sometimes become pathogenic? The relationship between bacteria, fetal membranes, and the intra-amniotic cavity is dynamic and poorly understood, as is the maternal immune response to those organisms.[1] Amniocentesis during preterm labor frequently detects inflammatory cytokines without a positive culture, meaning invasion of the amniotic cavity is not required to cause inflammation and preterm birth. Of all the commensal organisms suspected to play an etiological role in infectious/inflammatory

preterm birth and bacterial vaginosis, *Ureaplasma* and *Mycoplasma* species are perhaps the most amenable to treatment.[2] Identifying them during a preterm loss may help direct care: screening and treatment for bacterial vaginosis early in a future pregnancy and eradication of *Ureaplasma* and/or *Mycoplasma* in a woman and her partner before or early in a future pregnancy.

Treatment of atypical bacteria to decrease preterm birth has not been adequately studied.[3] Treatment of bacterial vaginosis with clindamycin appears to have better preventive effect than metronidazole, perhaps because clindamycin also covers *Ureaplasma* and *Mycoplasma*, whereas metronidazole does not.[2,4] We have not typically performed fetal cultures for *Ureaplasma* and *Mycoplasma*, and they require Universal Transport Medium for identification. Can Dr Terry comment on whether *Ureaplasma* and *Mycoplasma* cultures were done in any of the included autopsies? Might he suggest a suitable fetal site if a clinician were to test for them?

—Andrew Kotaska, MD, FRCSC
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Author replies

I appreciate Dr Kotaska's comments on the amniotic fluid infection/inflammation (AFII) autopsy quality assurance study recently published in the journal [*BCMJ* 2021;63:383-387]. The practice at BC Children's and BC Women's Hospitals is to sample for bacteria from areas that are unlikely to be artifactually contaminated at or after delivery, such as the lung and stomach contents. This study was not intended to assess the sensitivity and specificity of bacterial culture in the setting of AFII and as such a non-AFII cohort was not included for comparison; anecdotally, however, bacterial cultures from non-AFII cases at BC Children's and BC Women's Hospitals are mostly negative, which demonstrates the low level of detectable delivery and tissue sampling–related contamination.

Dr Kotaska makes the excellent point that the relationship between microbes, inflammation, and delivery continues to be poorly understood. A robust relationship between intra-amniotic microbes and AFII has been established; however, the recent application of highly sensitive molecular techniques for bacterial detection has failed to demonstrate detectable microbial DNA in all AFII cases; conversely, the presence of intra-amniotic microbes (particularly *Mycoplasma* and *Ureaplasma*) without any appreciable maternal inflammatory response has been convincingly shown. Thus, bacterial culture by itself is a poor diagnostic test for AFII but can be diagnostically useful in the context of histological AFII where bacteria are not seen microscopically. Dr Kotaska also makes the important practical point that bacterial culture presently has no predictive value as there is no robust data to support treatment to decrease preterm birth, although this is also not well studied.

Testing for *Mycoplasma* and *Ureaplasma* is difficult as these obligate intracellular microorganisms are fastidious and require special handling, as Dr Kotaska points out. *Mycoplasma* and *Ureaplasma* culture is presently not performed in British Columbia and the only locally available *Mycoplasma*/*Ureaplasma* testing is molecular based and not validated on placental tissue, so testing for *Mycoplasma* and *Ureaplasma* in the setting of AFII, or pregnancy loss in general, is not routinely done at our centre. If I were to test a clinical sample for *Mycoplasma* or *Ureaplasma* I would submit lung and stomach contents for culture-based studies or lung and stomach contents and tissue for molecular testing. The genomes of *Mycoplasma* and *Ureaplasma* may also be visualized fluorescently in the cytoplasm of infected cells, although this approach is more suitable to a research environment.

—Jefferson Terry, MD, PhD, FRCPC
Vancouver

Improving planetary health in BC: Taking small but important steps

It is becoming increasingly clear that our future health, as well as the health of future generations, is linked to global planetary health, including the preservation of the natural environment, appropriate use of resources, and engagement of sustainable systems.[1] The Board of the Vancouver Medical, Dental, and Allied Staff Association/Vancouver Physician Staff Association is very supportive of Vancouver Coastal Health's formal adoption of planetary health as a strategic priority via the creation of an official planetary health portfolio, with Dr

Andrea MacNeill leading the clinical services component. Dr MacNeill has given outstanding lectures on the subject to our membership at our annual general meeting in December, and more recently to our Board. It is clear that what may be perceived as small steps locally can lead to long-lasting positive consequences.

With this in mind, we strongly recommend that the *BC Medical Journal* consider publishing only online and cease publishing in print. Given the popularity and convenience of online medical journals in general, and the fact that Doctors of BC's services and communications have long been conducted electronically, we suspect that the Doctors of BC membership will quickly adapt to accessing and reading the *BCMJ* online. Reducing the carbon footprint associated with printing the journal (i.e., saving paper, ink, metal staples, and plastic wrappers, not to mention the production and distribution resources) will contribute positively to planetary health. It will also most likely result in cost savings to Doctors of BC. If the *BCMJ* takes a leadership role on this issue, we suspect that other association journals (e.g., *CMAJ*) may follow.

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Editor replies

Thank you for your letter. We agree with the small-steps approach and have been working to lessen our environmental impact for many years. The small steps that we have taken include:

- Supporting doctors who wish to read online-only by canceling their paper subscription and encouraging them to subscribe to *BCMJ Headlines*, a notification emailed when a new issue is posted on www.bcmj.org. This action directly reduces the number of copies we print.
- Avoiding bag use, and using recyclable paper envelopes when needed.
- Working with an environmentally advanced printer, Mitchell Press, certified by www.canopy.org.
- Printing with vegetable-based inks.
- Using FSC-certified paper.
- Printing locally.

Our recently completed member survey (January 2022) again asked about members' attitudes toward print versus online. As in previous years, a strong majority of members asked that we continue with print, and this preference holds when stratified for age and other demographic factors. The number of readers who favor print has diminished somewhat since the previous survey in 2016; this trend seems likely to continue, and perhaps in the future the *BCMJ* will become an online-only publication.

The *BCMJ*'s mission is to provide a forum for clinical education, medical news, opinion, and resources for BC physicians, and we—along with the majority of our colleagues from around BC—believe that this mission is best accomplished with a combination of print and online formats.

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—Ed