BCMJ
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Doctors of BC president, 2023
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Highly pathogenic avian influenza, notably of the H5N1 subtype, was detected in domestic poultry across BC and around the globe at unprecedented rates in 2022. A BC clinician's guide to diagnosis and management begins on page 27.

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.

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Are vitamins a complete waste of money?

Happy new year! How are those new year's resolutions coming along? If you are anything like the majority of Canadians,[1] your commitment has already lapsed, but that doesn't mean you should give up. Many of us are striving to be better in 2023. Taking vitamins can be an appealing option—no starving, chopping vegetables, or sweating at the gym; just purchase, pop, and improve. But is it really that simple?

In 2022, *JAMA* published a study conducted by the US Preventive Services Task Force to assess vitamin, mineral, and multivitamin supplementation to prevent cardiovascular disease and cancer.[2] It represents the most thorough meta-analysis to date of every randomized controlled trial of vitamin supplements in adults. The data did not provide a compelling endorsement for vitamins. In fact, an article on Medscape summarizing the research was titled "It's official. Vitamins don't do much for health."[3] So, which is it? Are vitamins helpful or not? It turns out that the data are not as clear as we might hope for.

Let's dig into the specifics a bit more. The *JAMA* study recommended *against* vitamin E and beta-carotene to prevent cardiovascular disease and cancer, with beta-carotene possibly *increasing* lung cancer risk in people who smoke or are exposed to asbestos. Regarding single agents (vitamin D, vitamin A, calcium, folic acid, vitamin B12, vitamin C, selenium, vitamin B3, and vitamin B6) and multivitamin supplements, it concluded that current evidence is insufficient to assess the benefits versus the harms of use. Pooled analyses did not show an effect on all-cause mortality, cardiovascular disease, or cancer, but the authors acknowledged the limited generalizability and heterogeneity of the data. Importantly, they also specified that their conclusions do not apply to children, hospitalized people, or those with a chronic illness or nutritional deficiency and reminded us that those who could become pregnant should take at least 0.4 mg of folic acid daily.

I am cognizant that there are many other determinants of health and the *JAMA* publication was looking only at prevention of cardiovascular disease and cancer. However, because these are Canada's two leading causes of death,[4] they are appealing targets for any intervention intended to improve people's lives. Canadians spend over $4 billion[5] annually on vitamins, minerals, and supplements, with the most commonly stated reason being "overall wellness." Is their money going to waste?

Canadians spend over $4 billion annually on vitamins, minerals, and supplements.

What we *can* say is that vitamins are not universally beneficial. In some cases they can cause harm, such as vitamin A with reduced bone mineral density, toxicity, or teratogenicity, and vitamin D–associated hypercalcemia and kidney stones. In terms of other products, we may not yet know which supplements are preventive of what, or in whom. Although taking a daily vitamin is low-risk, I am concerned that some people do not read beyond the Google summary before clicking to purchase. Furthermore, it's common to be taking more than one product and overlapping, thereby exceeding dose recommendations. Vitamin companies are clearly aware of consumers' short attention spans and desire for a quick fix. Some products even list the "benefits" right in their names. Perhaps the clever intention behind the Medscape article's oversimplified title was to elicit a pause; a concise interpretation of the data makes it easier to convey. But, as in many facets of medicine, more evidence and critical appraisal will be essential to inform our patients and help them navigate a potentially predatory market of unfounded promises.

As doctors we are often presented with a long list (or bag of bottles) of vitamins, supplements, tinctures, etc., which patients want us to review. "Are these pills worth taking, doctor?" they ask. How do you reply? It seems that, in many cases, the truth is that we really don't know. ■

—Caitlin Dunne, MD, FRCSC

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Speak-up culture = feedback culture

The *In Plain Sight* report recognized that Indigenous people experience racism in our health care system. The report recommended "that the BC government continue efforts to strengthen employee 'speak-up' culture throughout the entire health care system so employees can identify and disclose information relating to Indigenous-specific racism or any other matter."[1]

What is "speak-up" culture? How can it help us? How do we develop and nurture it within the health care system? I believe we can simplify the concept by thinking of speaking up in terms of providing feedback. In my experience, knowledge and skills are required to speak up well.

Speaking up through feedback can be a powerful tool to help us improve in our personal and professional lives, but it's not easy. In busy health care settings, it's sometimes easier to delay or avoid opportunities to give feedback.

Good feedback needs to be specific, actionable, timely, and delivered with compassion and curiosity. It takes practice! Providing feedback about explicit or implicit racial bias is even more complex due to the difficult emotions elicited. The person giving the feedback might feel anger, fear, or sadness. The person receiving the feedback will often feel shame.

Giving feedback about racism is not as common as it should be. Even if we want to, most of us do not know how to do it in an effective manner. When I give this kind of feedback, I try to provide it in a manner that protects those being harmed by the biased behavior without shaming the other person. Shaming people is not an effective social justice or educational tool,[2] as I can attest to personally. A friend of a friend posted an article on social media about questions you shouldn't ask same-sex couples who have kids. While out for dinner the week before I had asked one of these questions, and I went online to comment that I found the article useful and to apologize for not knowing better. But when I read a couple comments about how "stupid" people are, I didn't end up posting the comment or reaching out to apologize, because I felt attacked. I learned from the article but did so in shame and silence, and that relationship was never repaired.

Here are some principles for how to deliver feedback in a good way:

- Speak to the person privately.
- Establish a connection with the person.
- Ask them about the behavior you observed.
- Provide your feedback about the behavior observed.
- Keep the dialogue open.

These conversations can be difficult, which is exactly why these skills need to be taught and practised in order for people to feel confident to use them in the real world. As a cultural safety educator, I prefer "calling people in" rather than calling them out. Calling people in means you assume their intention was not to harm and that they do not understand the impact of their behavior, that when they know better they will do better.

Receiving feedback can also be difficult. It requires us to be open, reflective, and honest with ourselves. Understanding the trauma response and how to develop shame resilience can be helpful. Racism is often seen as a moral issue: you are either racist or you are not, and if you are found to be racist you are a bad person. Therefore, when someone is told their behavior is biased, they can feel as if their character is being attacked. This is followed by shame, which triggers a trauma response in the form of either fight (challenge), flight (deny, avoid), or freeze (blank, no words). These responses are all normal. When someone is in a fight, flight, or freeze response, they are able to respond only from their limbic brain; their prefrontal cortex is offline. In other words, they cannot listen to you meaningfully.

Shame thrives in secrecy and silence.[3] To counter the shame around racism, we need to be able to talk about it. We can use the same strategies that are used to address the shame and fear around acknowledging a medical error. This includes normalizing (i.e., we all make mistakes) and creating safe spaces to report and talk about medical errors (i.e., morbidity and mortality rounds). We all have racial bias because we grew up and live in a world with racial bias, including anti-Indigenous bias. We need to normalize that we can all be racist and create mechanisms to report racism and talk about racism. I would like to see education and training opportunities that teach how to give and receive feedback about racism developed and implemented at all levels of medical education so that we all feel empowered to speak up.

I believe having these courageous conversations will have a profound impact on preventing anti-Indigenous racism at the bedside and will save countless lives. ■

—Terri Aldred, MD

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Culture of hope

"Culture" is a word that defines all the little things that make us who we are: our origins, our ancestors, the places we call home, where we have come from, where we are now, and where we may long to go. The multiplicity of our culture is a delicate balance of our greatest attributes and our deepest flaws. It is a culmination of our superpowers and of our respective kryptonite.

The culture of our profession can be one of helping, healing, compassion, and understanding. And yet it can also be one of competition, suffering, and exasperation with the pressures we put on ourselves and those we feel are put upon us.

As we enter into 2023, we need to look at where we have been and where we are going. We need to look introspectively at the culture of medicine. But we need to first look inward, so that we can authentically look outward. And we need to look upon ourselves with compassion and kindness, while letting go of the competition and the guilt. Let us examine if "the way" we are or "the way" it is creates the right culture. Are we serving ourselves, our colleagues, and our patients well? Are we sharing in the culture necessary to lift each other up? Are we demonstrating to our patients that while we may have bent, we are not broken, and we are looking to the future with a sense of optimism and resolve? Are we exhibiting a culture of hope?

Unequivocally, there have been challenging times and unpalatable circumstances over the last few years. And yet, as Martin Luther said, "Everything that is done in this world is done by hope."

Many of us have witnessed a dying patient or someone who cannot resolve their own inner turmoil. They become destitute because they cannot see a path forward. They suffer needlessly because they cannot find something to look forward to beyond their immediate future. They have lost hope.

There is a renewal about us, our profession, and our association. We battled through the despair of the last few years and we rallied.

But we have not lost hope. Rather, I feel we have found a renewed sense of hope.

There is a renewal about us, our profession, and our association. We battled through the despair of the last few years and we rallied. We are leading with courage and defining what we want our health care system to look like moving forward. We are redefining what it looks like to not lose hope. This year is full of fresh starts: a renewed perspective within our association, a new Physician Master Agreement, and a new family practice payment model. Our advocacy work will continue in earnest on behalf of specialists and their concerns about emergency rooms, diagnostics, surgical wait times, community-based offices, and oncologic care. And 2023 has introduced us to a new CEO of the association, not to mention that we now have a new premier leading the province.

For all these reasons and more, I am very hopeful. I also come from a place called Hope. I have spent the majority of my medical career in this community and intend on carrying its ethos and culture forward. I believe in every one of you, as my colleagues and friends. I believe that no matter where we have been individually and collectively, we have it within us to carry and share in a sense of hope. We want it. We need it.

I am privileged to serve as your president for 2023. Over the coming year, I will write extensively about culture. I will write prospectively and optimistically about our collective future. I will speak in open forums and meet with you in quiet places. I will explore a multiplicity of our culture and reflect hopefully on who we are as a profession and as an association, and who we want to be. Above all else, though, I commit to you that these reflections and prognostications will be grounded in a culture of hope.

With gratitude. ■

—Joshua Greggain, MD
Doctors of BC President

Letters to the editor

We welcome original letters of less than 500 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.

Re: Gender-affirming care in BC: Guest editors reply to Drs Sinai, Regenstreif, and Leising

I was interested to read that the approach taken by the team at BC Children's Hospital requires a "comprehensive psychosocial assessment of an individual before providing gender-affirming therapy" [*BCMJ* 2022;64:287]. A family experience there is recounted in an article published in the *Economist* 2 years ago: "'We thought we were going to see a psychologist, but it was a nurse and a social worker,' says Ms Davidson (both her and her daughter's names have been changed). 'Within ten minutes they had offered our child Lupron.'"[1] Was this an adequate psychosocial assessment? The parents clearly did not think so.

Why has there been such a huge increase in referrals of children (especially girls), unhappy with their birth gender? Perhaps if we knew the reasons, we could put our resources to better use. Meanwhile, I am concerned that these youth may need more time to consider their decision.

—Richard S. Taylor, MB, BS, FRCPC
Victoria

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Designation of a life insurance beneficiary

Erin Connors' article about designating your life insurance beneficiary [*BCMJ* 2022;64:377] has solid, poignant information, recommending that you designate a beneficiary for your policy in the case of your death and ensure that you stipulate a trustee to handle the funds if the beneficiary is still a minor.

When our son unexpectedly died 20 years ago without having made a will, nephews had been named as beneficiaries of his two policies. The one living in BC immediately lost 10% of the payout to the public trustee, who had to handle the funds under BC law. The one living in Quebec was able to avoid this by having his parents designated as trustees.

Another BC peculiarity, and a catch-22, is that to administer an intestate estate one needs letters of administration, which can be obtained only if details of items like life insurance policies are given up front. But to get those details, insurance companies demand that you provide them with letters of administration!

Perhaps the insurance department of Doctors of BC could spearhead changes to probate law in BC to remove this legal incongruity and to make it possible for parents to administer life insurance policy benefits for minors under the supervision of a public trustee, as is done in Quebec, without the large windfall deduction from those funds.

—Anthony Walter, MD
Coldstream

Re: Dr Ken Turnbull (obituary)

I was saddened to read of the passing of Dr Ken Turnbull. He was one of my favorite teachers, colleagues, and mentors.

In 1986, when I was a resident, he was one of the ICU attending staff. He had a great way of assessing cardiovascular responsiveness. He used the tilt table test. No one else did. Little did I know at the time that the test was first described that year!

Later, when the two of us were both in practice at VGH, he gave anesthetics for my patients. He was one of the early adopters of acupuncture as an adjunct to

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general anesthesia. He liked to teach about the Hegu point (LI4) in the first web space. This is the one to relieve headaches (possibly caused by the interaction of surgeons and anesthesiologists).

In 2001 I required an emergency discectomy for an acute L5-S1 disc. Ken was my anesthesiologist. He sent the medical student out to examine me preoperatively. She apologized and said that Dr Turnbull had told her that she had to listen to my heart and lungs. I think I told her I would tell him if she didn't.

He loved to talk about tinkering with and flying his plane and the time he had to ditch her in Indian Arm. He was a great teacher. He cared about his students, his patients, his colleagues, and his profession. He was also a good friend, and I will miss him.

hay č xʷ q́ə.

—Douglas J. Courtemanche, MD, MS, FRCSC
Vancouver

Correction: Managing menopause Part 1: Vasomotor symptoms

This article (*BCMJ* 2022;64:344-349) has been revised online postpublication to provide an alternative method of accessing the *Managing Menopause* guideline via the College of Physicians and Surgeons of BC Library.

Revised content: The *Managing Menopause* guideline can be accessed from the College of Physicians and Surgeons of BC Library. To do so, go to the Point of care tools page: www.cpsbc.ca/registrants/library/point-care-tools and find ClinicalKey in the alphabetical list. Click on "Log in to access" and log in. Scroll down and click on the Guidelines box (left-hand side). Where it says "filter list by title," type "guideline no 422" and press the Enter/Return key. College registrants with library services can contact the library for assistance (medlib@cpsbc.ca); other health care providers can use the citations in the reference list (2-8) to inquire further at their own libraries.

Correction: WorkSafeBC and your patients with workplace injuries: Frequently asked questions

The WorkSafeBC article published in the December issue (*BCMJ* 2022;64:432) has been revised. The authors requested the highlighted changes post-publication:

Q: How do I know if my patient's claim has been accepted?

A: You can check an injured worker's claim status by using the claim status tool at https://pvc.online.worksafebc.com or calling the ~~Teleclaim team (604 232-7787 or 1 866 244-6404 toll-free~~ WorkSafeBC Claims call centre at 604 231-8888 or 1 888 967-5377, Monday to Friday, 8 a.m. to 6 p.m.~~, or emailing hcsinqu@worksafebc.com~~.

Dr Joshua Greggain: An optimistic advocate ready to engage

Dr Greggain has been a family physician caring for rural, Indigenous, and underserved populations for the past 15 years and is the new president of Doctors of BC. Here he shares a bit about where he comes from, what inspires him, and what he hopes for the future.

Dr Greggain started his 1-year term as president of Doctors of BC on 1 January 2023. He spoke with *BCMJ* editor Dr Caitlin Dunne in December.

First of all, congratulations on your role as president of Doctors of BC. I'm excited to learn more about you; based on your lived experiences and your overall outlook on medicine, there's so much I could learn from you, and I'd like to give you a chance to introduce yourself to the readership, and maybe tell us about your background.

Congratulations to you as well, on your new role as editor.

I feel like in medicine we talk a lot about what we do for a living—this is my job—and I try to frame my introduction around what we call human being, human doing. I'm Josh Greggain; I'm a husband, father, uncle, and grandson, and eventually will become an ancestor, although I'm hoping that's still a long time off. I'm privileged to be married to Jennifer. We have two children, Darren and Elizabeth, 25 and 21, which is why I preface that with I don't want to be a grandparent or an ancestor yet. I'm privileged to be a family doctor. I'm privileged to be a White settler on the territory of the lək̓ʷəŋən-speaking people in Victoria, where I've spent the last year, and I've had a really good career, I think, in rural medicine in British Columbia over the last 20 years, give or take, primarily in the communities of Hope and the Fraser Canyon.

You've both lived and worked rurally for most of your life and career, and you started your work with Doctors of BC on the Rural Issues Committee. Tell me something about rural issues that city docs should know, or that you want us to know.

I have the privilege to teach a course with the Practice Ready Assessment International Medical Graduate program, and I always start with a statement to the effect of "Rural family medicine is

the most rewarding, most fantastic, most exciting profession in the world, and everyone should try it for at least a week, if not a month, if not a lifetime." There are lots of predictors of why people do rural medicine; for me, it was a combination of growing up rurally in Northern Alberta, having my father be a rural family doctor, and recognizing all of the things I would get to do.

A couple years ago, I was honored provincially with an award in family medicine, and it was an opportunity to reflect. For example, I've known four generations of one family and I've seen all of them in a given week. I've had the privilege to be in the emergency room, occasionally in the delivery suite, in the office, in our outreach communities, in the hospital, and on house calls, and there aren't too many jobs where we get to do all those things at different times. For me, the rural nature has something to do with generalism but also a ton to do with being connected to people, which I've always really enjoyed.

It was the inclusiveness taught to me by Chief O'Donaghey in 2009 that started to create opportunity.

Is there a story or family that stands out to you, that connected with you in your career?
I've been *practising* family practice since 2005, which feels like both a long time and a blink of time. For sure, walking alongside families who have lost children have been some of the most difficult times in my career—to be at the wake, to be at the funeral. Those are times that are pretty special. One patient who passed away earlier this year had given me a vial of gold that he had sluiced out of the Fraser River. He was well into his 80s when he did that.

You often speak about connections, whether between you and your patients or you and your colleagues, working in, say, Fraser Canyon, Chilliwack, or Hope. Is that what drives you?
Absolutely. I'm a people person. I like to connect with people and create opportunities for authentic connections. In the world of social media, being someone's Facebook friend or following them on Instagram is not the same as being there when their house is flooding or helping someone (or being helped) during a challenging time. I had a colleague reach out this week to say, "Man, I had a really tough week." I'm always happy to be there to have a conversation. Whatever I've given out to my colleagues has come back to me tenfold.

Even though I'm living in Victoria now, I stay connected to many of the people I've worked with over the years, and we continue to share a multitude of circumstances.

Tell me about your view on optimism. I am inspired by the optimistic tone of everything you write. How, in this difficult time in medicine, as many of our colleagues are struggling with burnout, financially, or with the various commitments they have in their lives, does one become more optimistic?
There is an element of nature versus nurture; some people are generally more optimistic. I have that gift. I see the glass as half full, and I ask myself, how can I pour more into it to create opportunities for other people that will ultimately overflow and pour out even further? I appreciate what you said; I do bring a particular tone. I am pretty excitable, maybe overly enthusiastic at times, and that has served me well—in the exam room, managing people, at the community level, or when thinking about what the future holds. At the core of optimism for me is the absolute belief that we can do something differently or better, or that we can just *do* something. It aligns with who I am as a person, and it then tends to be a bit infectious. I've been labeled gung-ho-ish in my family. It comes from a place of courage, confidence, and compassion for oneself and for others. It's a space to think, let's get this done, no matter what it is.

I agree, it is infectious. Maybe your optimism can be our new infectious disease. That would be beneficial.
Yes, the virus of hope. When I stepped into the opportunity for this role just over a year ago it was with that tone. I can't say I'm well versed in all the policies when it comes to health care or that I know what it is to be every one of the 15 000 physicians across this province, but I do know how to set a tone and create space for people, both inclusively and optimistically to move forward.

Let's talk a bit about inclusivity and one of the themes that I also took from your writing, which is your relationship with the Indigenous community. I want to give you some space to talk about that.
I've worked for 17 years in a community that has up to 25% Indigenous people. Earlier in my career, we weren't talking about First Nations health or about Indigenous cultural safety and humility. You just saw patients. There wasn't a lot of distinction. I was invited in 2009 into the development of the primary care clinic in Anderson Creek, which is about 1 hour north of Hope, in the community of Boston Bar. And what was really inspirational at that time was when Chief Dolores O'Donaghey said, "We want to build this space [at that time] with Health Canada dollars and we want to make the space inclusive of everybody." They didn't want to have the clinic on reserve to be only for Indigenous people. It needed to be for everybody, because the challenges, both remote access to health care and some of the demographics, were the same for everybody. It was the inclusiveness taught to me by Chief O'Donaghey in 2009 that started to create opportunity. Initially I was able to be in clinic once every week or two alongside one of my colleagues and nurse practitioner Sean Young, from Agassiz; we started to see some of the challenges faced both on reserve and also generally by people in remote locations. I couldn't get everyone to an MRI or a CT scan—I could hardly get them down for their labs—but we could sit and connect and walk through whatever circumstances came through that door.

And we did. I've done house calls and car calls and boat calls, where you go to someone's house or car or boat or hotel that they're living in to help make sure they know they are cared for. I say that coyly, but that's one of the privileges of being a rural physician: I get to go to all sorts of places, and, as a result, when you do those things, people feel like you care for them, and when they feel like you care for them, not only do they *feel* better, whether they get better or not, but I know that I've helped inspire them a little bit. Most importantly, like Chief O'Donaghey did early on in my career, I was inspired to do something different or more.

I was happy to read about your commitment to cultural humility, inclusion, and diversity, because I think we are all learning about that. Can you share with us any further insights? What's the best advice you've received on how to approach this topic or how health care should embrace this topic?

I'll start with a professional commentary and then I'll go personal. If there's any profession that recognizes that we're all just *practising*, that none of us have this mastered or perfected, it's us in health care. I jokingly say that I'm either in training, practising, or retired; there isn't anything in between. There's an inherent humility to the profession that I think at times we forget about, or at times *I* forget about. Sure, I'm a doctor and I know things, but the reflection for me is that I may know physiology, anatomy, prescriptions, or diagnostics, but I don't actually know people's lived experiences. If I can approach my exam room with that sort of sensitivity or the emergency room with a sense of humility—that I need to understand this person, where they're coming from, their human being alongside their human doing—then that creates space for me personally to better listen to them. One of the Elders that I know quite well in Chilliwack, a woman named Gracie Kelly, taught me about being humble. Being humble is often about wanting to hear people's hearts. She taught me to listen with my three ears, the two on the side of my head and the one in my heart.

I am White; I am not Indigenous. I have had all the privilege of a lifetime of education and resources and being free of trauma, and that isn't the case with many people in our Indigenous communities.

Following the discovery of children's graves at the residential school in Kamloops, it registered that people in my communities have gone there; I know patients who had family members go there. That introduces a whole other level of reflection on what it is to be a healer, what it is to be someone who cares for people, and what it is to be Canadian. What it is to understand our heritage, my ancestors, our colonialism, and what I can't do to fix that, but what I can do to open the circle a bit larger, to invite people in for conversation, to meet in community, and ultimately to meet in the exam room to make sure I've acknowledged the truth, that I can be trusted to the best of my ability, and that I want to help patients heal from whatever circumstances they've seen.

I love that idea—to borrow the phrase you borrowed—to listen with your three ears, and how that third ear in your heart helps you understand people's lived experiences, and that the lived experience is an integral part of the patient history. It's another diagnostic test. It's part of the big picture of understanding how to help a patient with whatever their ailment may be.

Absolutely. And if it's a skill that I can own, it makes me a better listener, which makes me a better partner, which makes me a better father, which makes me a better son. I think in medicine some

of the burnout we've experienced, some of the challenges we've faced, have been because we've lost some of the humanity, both in what we express to others and in the grace we don't extend to ourselves. Part of walking alongside people is also being authentic with yourself.

Shifting gears a bit, what has this past year looked like for you as president-elect?

I had to ask that question as well, a year ago. I'm privileged to know some really great people who have been past presidents. I know Ramneek Dosanjh a little bit, I know Matt Chow reasonably well, I would consider Trina Larsen Soles and Alan Ruddiman close friends, and Granger Avery is a mentor of mine. They are people I hold close. The advice Alan Ruddiman gave me was to use the time to make connections, to build out opportunities to connect to people, to understand the landscape, to understand the circumstances. I've been involved with Doctors of BC officially since 2019 via the Rural Issues Committee and the Joint Standing Committee on Rural Issues, but I hadn't been in the boardroom or at the representative assembly. So, this past year was spent initially trying to navigate some sticky situations regarding leadership and Board composition, and then it was getting to know my fellow Board members, the Joint Collaborative Committees co-chairs, and some of the staff.

May was a bit of a tumultuous time in the province when it came to the legislature, a rally around patients, and trying to give primary care a different scenario. I started to reach out to local physicians here in Victoria that I knew, local community activists, and I had the privilege to continue to understand and listen with my "three ears" about circumstances, which led to opportunities to be invited to the Ministry of Health to try to understand what the future holds and then be able to shape and form what it is going to be. Because it's a Physician Master Agreement year, in the latter half of the year I was involved in some of the negotiations and involved intimately in the longitudinal family practice model. I think that model and the opportunity to create some elevation of primary care in the public's eye were important to inspire our colleagues and the entire system.

The year was about connections, relationships, and listening, and then starting to build what will be the tone for the next year in the culture of medicine.

But I've also done my best to create time and space for travel with my family. We were in Scotland for 3 weeks. We spent 10 days in New Zealand. I've been able to fly to Regina to visit my grandmother and head to Seattle with friends. It's been a busy year, but it's been a fun year.

From my perspective, my task this year is not to share my voice, but to reflect the voices of my colleagues.

If we could fast-forward to the end of your year as president, what would success look like for you?

The biggest thing for me is to try to bring to the table what I have and what I know. If a year from now my colleagues, collectively or individually, feel more inspired to do what we need to do, if they feel more hopeful about the future, if they have created more space for more people to be involved in clinical conversations, more opportunities for engagement with their colleagues, patients, and communities, I will feel like things have gotten better. Our motto at Doctors of BC is "Better Together," so I want to send that message. I'm also expecting to be able to travel more across the province as things have opened up, because it is a privilege to meet and listen to people and hear them create a sense of unity and connection, and then to move us forward during a time when it's so important that physicians continue to be trusted people in this province, and those who can lead into the future. We are at a time of significant transformation in BC, and I want to ensure every one of my colleagues across the province shares the same sense of hope that we have it within us to shift and renew a system. It is critical that we set the tone and are at the core of that renewal.

I think what I heard you say is that you're going to leave our readership more optimistic and more cohesive than you found it. I look forward to that.

I will aspire to that, Caitlin. Obviously, I can't enact those things alone, but I can hopefully inspire and create opportunities so that people can make that happen. I'll continue to write over the course of the year about the culture of medicine, trust, hope, and sustainability. All those things are important, and I expect to live those out in my own life. Optimism and creating space to celebrate who we are, what we do, how we're seen in the culture and community, and how we, therefore, have the opportunity to be trusted and to trust others.

I want people to know how inspired I am by our colleagues and our readership, and that I hope we can reflect that inspiration back on one another. Ultimately, from my perspective, my task this year is not to share my voice, but to reflect the voices of my colleagues, and that reflection will amplify the optimism and positivity that's out there, while still acknowledging the challenges, but hoping we can spur or inspire each other forward. ■

Advancing health equity: The quintuple aim

Since 2008, the triple aim framework[1] has supported health care improvement through the simultaneous pursuit of three goals—improving population health, enhancing the care experience, and reducing costs—to optimize health system performance. The triple aim was expanded to the quadruple aim in recognition of the growing challenge of burnout (i.e., exhaustion, cynicism, and professional dissatisfaction) among physicians and the health care workforce.[2] Now there is an imperative to advance health system improvement beyond the quadruple aim to the quintuple aim, with simultaneous advancement of health equity, purposefully focusing on individuals and communities who need improvement and innovation the most.[3]

Health equity is defined by the World Health Organization as "the absence of avoidable or remediable differences among groups of people."[4] It is achieved when everyone can attain their full health potential and no one is disadvantaged because of social position or other socially determined circumstances. While Vancouver is one of the healthiest cities in the world, life expectancy between neighborhoods just 5 km apart can vary by as much as 9.5 years; some neighborhoods have mortality rates 17 times higher than others.[5] Some of the areas with better outcomes have more services, more green space, and more transit; there may be attribution to specific policies and social factors that are remediable.[5] Living conditions are often made worse by discrimination, stereotyping, and prejudice. Discriminatory practices are often embedded into institutional and systems processes, resulting in underrepresentation in decision-making at all levels and underservice.

A person's physical and mental health and well-being are influenced by social, economic, and environmental factors, which can cluster in populations. Protective factors include access to a healthy diet, physical activity, education, stable employment, a stable support network, and quality housing. Risk factors include smoking, adverse childhood experiences, exposure to violence, and alcohol and drug misuse. Without an explicit focus on reduction of disparity and correction of systemic inequities, the opportunities to promote or restore health and well-being can be lost. Addressing inequity benefits current and future generations.

While Vancouver is one of the healthiest cities in the world, life expectancy between neighborhoods just 5 km apart can vary by as much as 9.5 years.

Primary health care has strong potential for reducing health disparities. Fostering innovation and development of integrated community-based care can be critical to reducing disparities. Low-income people have greater prevalence of chronic illness and fewer resources to manage them. They have poorer housing, less access to transportation, and less income for prescriptions and healthy food. Finally, they are less likely to have strong social supports. Not only do these factors affect mortality rates of chronic diseases over time, but they are also drivers for acute health crises, such as the opioid overdose crisis and the COVID-19 pandemic. Services that are centrally located, are designed to fill support gaps, and provide outreach for early detection, follow-up, and ongoing care will reduce disparities. The best model includes health care teams of multiple providers, with coordinated, continuous, relationship-based care provided by community longitudinal family physicians and practice teams throughout a patient's lifetime.

There is an urgent need to address the inequities caused by unjust and unfair factors within health systems. Adopting the quintuple aim will lead to reduction of disparity and correction of systemic inequities to improve conditions of daily life. With patients as our partners, we must all be learners and active participants in decolonizing BC's health care system, returning the right to access quality health care that is safe and free of racism and discrimination. Health systems should alleviate challenges that people face, not add to them, and facilitate access to the care that people need. ■

—Katharine McKeen, MD, MBA, FCFP
Member, COHP

This article is the opinion of the authors and not necessarily the Council on Health Promotion or Doctors of BC. This article has not been peer reviewed by the BCMJ *Editorial Board.*

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Supportive cardiology: Bridging the gaps in care for late-stage heart failure patients

Interactive tools were created for patients with advanced heart failure and their clinicians to improve information sharing regarding living with the disease, managing symptoms, and making end-of-life decisions.

ABSTRACT

Background: Embedding a palliative approach into management of advanced heart failure remains an important yet challenging aspect of the current care model.

Methods: Late-stage heart failure patients were interviewed about their health care journey, and themes were extracted by multidisciplinary partners. The project team created two original interactive tools for patient and provider perspectives.

Results: The tool for patients and their carers supplements discussions with clinicians regarding prognosis. It focuses on recognizing signs and symptoms of heart failure progression and exacerbation and outlines skills for adapting to this transition. The aim of the clinician tool is to support clinicians' skills in caring for advanced heart failure patients. It includes guidance through the stages of care and interactive links to further information and support.

Conclusions: Two novel tools were created to address gaps in existing heart failure guidelines and patient education regarding advanced heart failure trajectory that were identified by patients and their providers.

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Background

More than one in five Canadians are expected to experience heart failure during their lifetime, and an estimated 600 000 Canadians are currently living with the condition.[1,2] Through improvements in diagnostics and treatment of cardiac events, heart failure has become a common endpoint for patients with advanced stages of cardiac decline.[1,3] Heart failure mortality has long exceeded deaths from lung, breast, and prostate cancer combined and has a 1-year mortality rate of 23.4%. Further, up to 80% of heart failure patients will be hospitalized during the last 6 months of life and are more likely than cancer patients to die in the inpatient setting.[1,4-6] Prognosis aside, the disease course also brings with it a multitude of symptoms that limit quality of life, including fatigue, dyspnea, angina, anxiety, and depression.[7]

The progressive nature and terminality of heart failure remain poorly appreciated by patients and their caregivers. Ambardekar and colleagues demonstrated discordance between physician and patient perceptions of prognosis and candidacy for invasive measures in advanced heart failure.[8] The Social Worker–Aided Palliative Care Intervention in High-risk Patients With Heart Failure trial further supported this misperception by showing a frequent overestimation of life expectancy in patients at high risk of heart failure mortality.[9] The deficit in both end-of-life communication during heart failure and specialist palliative care access has been increasingly recognized over the last decade and beyond. In a 2009 position statement, the European Society of Cardiology addressed the discrepancy in palliative care involvement between heart failure and oncological conditions, despite heart failure being considered equivalent to malignant disease with respect to symptom burden and mortality. Jaarsma and colleagues provided recommendations regarding the timing of a palliative approach, specifically that discussions about goals of care and prognostication should occur early and be revisited frequently.[10]

The integration of a palliative approach into the active management of evidence-based heart failure care remains challenging. As the population ages and the number of patients requiring palliative care increases, specialized palliative care physicians must focus on patients with the most complex biopsychosocial needs due to limited capacity.[11] These providers rely on a palliative approach being applied by clinicians of all disciplines to their full scope of practice; for patients with heart failure, that includes the cardiologist and primary care provider. Primary care providers are not always aware of whether their patient is eligible for further disease-modifying cardiac care and, therefore, may expect the cardiologist to convey prognostic information to the patient if this is not possible. However, cardiologists receive little formal training in palliative care, despite frequently encountering such scenarios, and may feel ill-equipped to host discussions about palliation with patients.[12,13] As a result, the subjects of disease progression and prognosis are often absent in their clinical encounters until a very late stage.[14-16] In terms of feasibility, Gandesbery and colleagues incorporated a palliative medicine service into their heart failure outpatient clinic to achieve an embedded model of care.[17] O'Donnell and colleagues similarly used a palliative approach that involved early conversations on quality of life, prognostic understanding, and end-of-life preferences, which were led by a social worker trained in palliative care; this intervention resulted in both improved documentation of advanced care preferences and patient readjustment of initial baseline prognostic estimates.[9]

Recognizing the challenges for advanced heart failure patients in accessing a palliative approach to care before the final days of life, we explore the gaps in the patient care journey and identify opportunities for improvement. The objective was to create mirrored tools for patients and clinicians that address the same issues but from different perspectives and thereby support improved care and communication for the patient and enhance clinicians' skills. We outline the needs assessment used and describe the creation and implementation of two interactive tools that were informed by patient experience.

Methods

Patient population

The project was conducted in Victoria, British Columbia. Adults with advanced heart disease (n = 10) were invited by their primary care provider to participate in an hour-long interview about their illness experience. Criteria for recruitment included a diagnosis of advanced heart failure with symptoms refractory to maximal medical management and one or more heart failure hospitalizations in the last year. Following national policy and the use of the ARECCI Ethics Screening Tool, this initiative was deemed to be a quality improvement study and was exempt from formal ethical review per Article 2.5 of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2018).

Education is paramount in setting expectations of the patient and their carers.

Initiative

This project was spearheaded by two physician leads: a cardiologist and a family physician with a focused practice in palliative medicine. The objectives were to improve the quality of life and prognostic awareness of late-stage heart failure patients and their carers and increase the comfort and skill of primary care providers in caring for this patient population.

Two novel partnered tools on advanced heart failure were created for clinicians and patients; each is embedded with palliative approaches. The tools were created as original material by the project working group, composed of the physician leads, a heart function clinic nurse clinician, and a cardiology social worker, as well as primary care providers and specialists in cardiology, palliative care, and internal medicine. The iterative process of tool creation began with a multidisciplinary team meeting in April 2019 to identify a standard clinical pathway for late-stage heart failure patients. Interviews with advanced heart failure patients and their carers were conducted by a cardiology social worker, which provided the group with vital information to identify gaps in the care pathway and determine the most appropriate and relevant content for the tools. Common positive themes included access to and support by primary care providers; challenges identified included inadequate symptom and medication management, system navigation, information sharing, and timing of prognostic conversations. A subgroup was created to include patient partners with lived cardiac experience, who played an integral role in ensuring the patient tool was written in a manner that was applicable to the target audience.

Two plan-do-study-act cycles were completed in January and February 2021 with a focus group of clinicians who reviewed tool content, advised on revisions, and provided recommendations to ensure that the two tools remained complementary.[18] One of the overarching goals of the tool creation was to ensure ease of user experience. To facilitate this, the tools were created through a low-tech platform as interactive PDFs to maximize their use by patients and providers. The content aligns with current recommendations from the most recent practice guidelines from the Canadian Cardiovascular Society, Cardiac Services BC, and BC Centre for Palliative Care.

Results

The tools

The clinician tool, which focuses on delivery of care from the primary care perspective, is divided into three stages of advanced heart failure: (1) transition to late-stage heart failure, (2) periodic assessments and/or exacerbations, and (3) actively dying. Each stage provides guidance on communication, symptom assessment and treatment,

disease modification, and optimization of daily functioning. The platform provides hyperlinked content to respective sections and chapters within the tools and external links to evidence-based resources to supplement the information within the tool. Therefore, the tool provides guidance on issues that arise during the three stages of advanced heart failure and addresses the information needs of multiple clinician groups by providing easy-to-follow prompts and step-by-step descriptions. The aim of the clinician tool is to support clinician skills in caring for advanced heart failure patients [Figure 1]. The tool is available at https://pathwaysbc.ca/ci/5231.

The tool for patients and their carers focuses on recognizing signs and symptoms of heart failure progression and exacerbation and outlines skills to adapt to this transition. It also includes diagrams of disease trajectories, helpful questions to ask, and future conversations to consider. The language provides clear information for the patient, as well as recognition of the carer's role and needs. This tool also has links to additional resources, which allows the patient to access as much or as little information as they require, at the appropriate time in their health care journey. The overarching purpose of this tool is to foster empowerment and preparation for active participation in discussions and decision-making with the health care team [Figure 2]. The tool is available at https://pathwaysbc.ca/ci/5230.

In June 2021, the interactive tools were made available to Vancouver Island users of Pathways, a provincial online resource

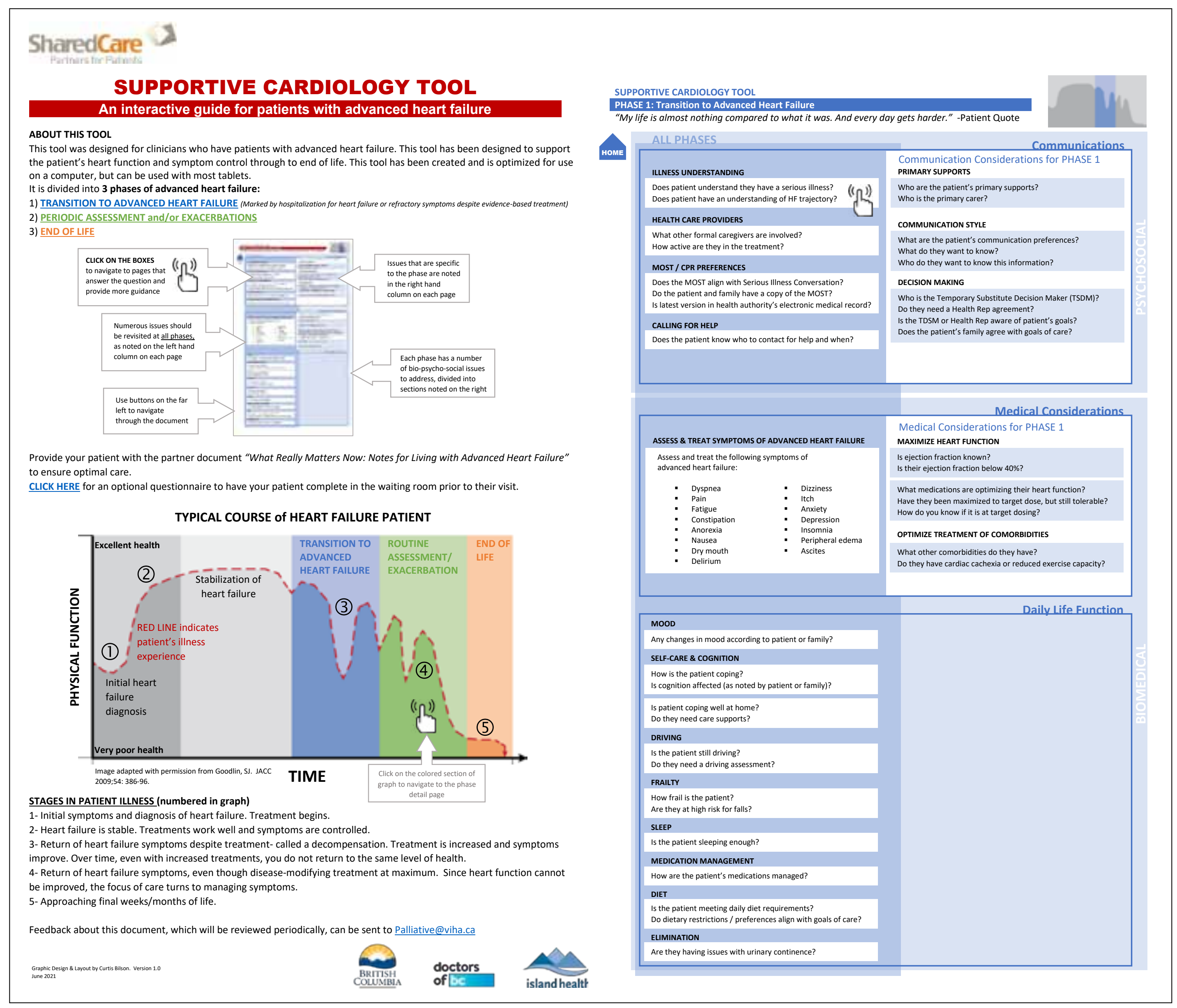

FIGURE 1. Screenshot of the clinician tool (https://pathwaysbc.ca/ci/5231).

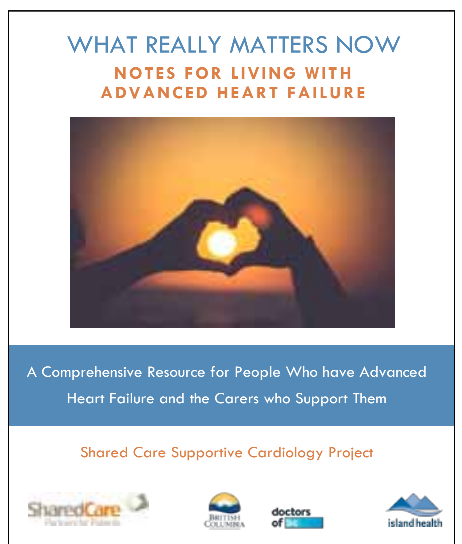

FIGURE 2. Screenshot of the patient tool (https://pathwaysbc.ca/ci/5230).

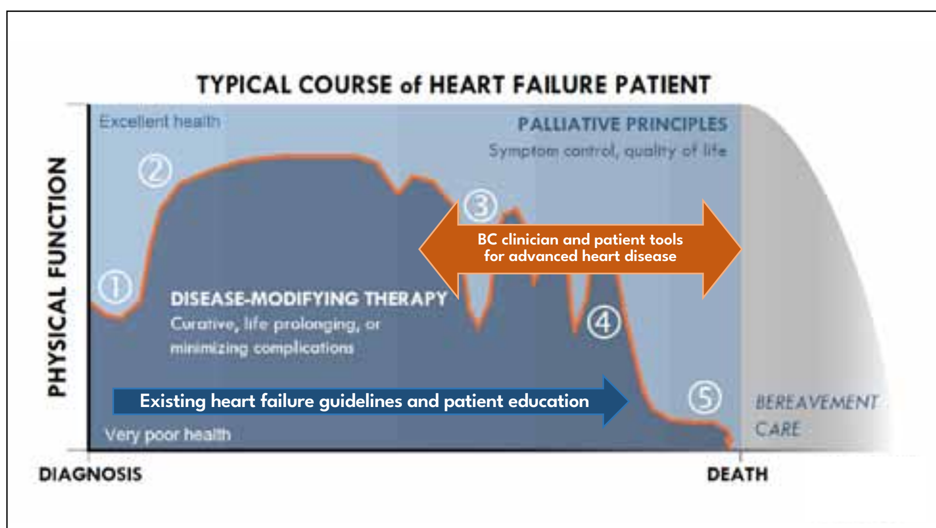

FIGURE 3. Trajectory of heart failure, with a timeline showing where existing guidelines and education extend and where the clinician and patient tools can bridge the gap.
Image adapted with permission from Goodlin SJ. JACC 2009;54:386-396.

for physicians and their staff supported by the Family Practice Services Committee that provides categorized and searchable patient and physician content. The tools are also available on the Island Health intranet, and work is underway to make them available to Pathways users across the province. The patient tool is currently distributed to patients seen at the heart function clinic in Victoria. Further distribution is being conducted through educational rounds provided to local physician groups. The intention is for the tools to bridge the gaps in existing heart failure guidelines and patient education regarding the disease trajectory **[Figure 3]**.

Discussion

Heart failure is a common, life-limiting illness with an often unpredictable disease trajectory. Its course is unique and challenging and entails navigation of the health care system with multiple care providers. Thus, when a patient is diagnosed with heart failure, education is paramount in setting expectations of the patient and their carers. Similarly, ensuring provider comfort and aptitude in navigating a palliative approach is of utmost importance in promoting effective communication between patient and clinician.

Concurrent administration of supportive palliative care alongside evidence-based disease-modifying therapies is advised in the literature.[10,19] Nonetheless, it has also been well recognized that palliative care is often missing in the provision of comprehensive patient care in late-stage heart failure.[10,14-16] Due to the finite availability of palliative care specialists, ill-defined roles among other providers in addressing palliation, and concerns about insufficient training in palliative care, patients with advanced heart failure are frequently not given the information they need to navigate their care and end-of-life decisions.[11-13] This is further supported by our needs assessment of the patient experience: common themes included challenges regarding information sharing with their provider, symptom management, and lack of understanding of their condition. It is essential to highlight the frailty of this patient population: most interviewees did not survive to completion of the project. Mapping the patient journey of those with advanced heart failure has provided improved understanding of their unique experience and the landscape of care for this patient population, as well as a recognition of the importance of primary care providers as a foundational support.

Summary

Two novel interactive educational tools geared toward patient and clinician perspectives on advanced heart failure were created. They include palliative approaches and considerations that can be incorporated early in the course of caring for these patients. The aim was to better support these audiences by using documented patient experiences and project objectives as guidance. Through the creation of the clinician tool, it is hoped that widespread education about the use of palliative approaches in late-stage heart failure can be achieved in a sustainable, independent manner. Given that the documented patient experiences reiterated the deficit of a palliative approach described in the literature, the patient-focused tool is intended to serve as a supplement to provider communication in managing patient and caregiver understanding of disease state and progression, providing considerations in difficult conversations, and offering available resources.

Study limitations

This work is limited in that patient experiences were obtained from a small, homogeneous population that represented most heart failure patients in our geographic region. We acknowledge that there will be differences in patient preference regarding the tools' level of detail and areas of emphasis. To mitigate this potential barrier, we recommend that these tools be culturally adapted to improve their relevance

to different populations. Ease of use may also be limited because the tools exist in an online, interactive format, which requires technological literacy; therefore, they may not be accessible to the elderly population afflicted with advanced heart failure. The patient tool can be printed, but the length of the clinician tool without the capacity for its interactive, hyperlinked function may preclude use in a paper format. Until adequate time is allowed for providers to incorporate palliative approaches earlier in the disease process, clinical utility of the tool remains to be evaluated.

Next steps

The goal of this project is widespread dissemination of the patient and clinician tools. Further work is ongoing to create connections across the province and beyond to facilitate distribution of the tools on a large scale. The hope is that with increased use, familiarity, and time since implementation, an assessment of clinical utility and patient experience can be completed. ■

Competing interests

None declared. Funding sources had no involvement with the project.

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Ensuring provider comfort and aptitude in navigating a palliative approach is of the utmost importance in promoting effective communication between patient and clinician.

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Opioid overdose following surgery or pain treatment: A missed opportunity for intervention

Patients who undergo surgery or pain treatment may later present with opioid overdose. Health care visits provide an opportunity to prevent repeat overdoses, recurring health visits, and premature death.

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ABSTRACT

Background: British Columbia has been the epicentre of the opioid overdose crisis since declaring it a provincial public health emergency in 2016. Effective strategies to reduce mortality are currently lacking.

Methods: This retrospective observational study included patients who presented to local emergency departments with opioid overdose during a 12-month period (1 July 2018 to 30 June 2019). We extracted demographics and overdose history and characterized hospital visits for pain or surgery within 24 months prior to the overdose.

Results: We identified 1104 patients who presented with overdose, of which 77% were male (n = 854), with a mean age of 41 across all patients (SD = 12). Within 24 months prior to the overdose, 50% of the cohort had a health care encounter for pain, and 5% had presented for surgery or a surgical procedure. Most patients (57%) had experienced a prior overdose (median = 2 prior overdoses; range = 1 to 28). Patients who had a prior health care encounter for pain or surgery were more likely to have had a previous overdose than those who did not have an encounter (66% vs 47%, respectively; $P < .00001$). Among those who had a previous overdose, there was a significant association between having prior pain or surgery visits and multiple prior overdoses ($P = .0006$).

Conclusions: Prior health care encounters for pain and surgery are common among people who present with opioid overdose. These visits are opportunities to prevent repeat overdoses, recurring health visits, and premature death.

Background

Canada is currently experiencing an opioid overdose crisis that is having devastating consequences for individuals, communities, and the health care system.[1] Since British Columbia declared a provincial public health emergency in 2016, the province has struggled to gain control of the epidemic as opioid overdoses and deaths continue to rise, as evidenced by the largest number of deaths ever recorded in 2021.[2] Within BC, the highest number of paramedic-attended overdoses, emergency department visits, and illicit drug toxicity deaths have occurred in the Metro Vancouver region.[2,3] In downtown Vancouver, St. Paul's Hospital in Providence Health Care is uniquely situated at the centre of Canada's opioid overdose crisis. The emergency department serves one of Canada's

poorest urban neighborhoods and receives high volumes of overdose-related visits.

There is an urgent need to identify strategies to mitigate the opioid crisis and provide effective intervention. Many people who die of opioid overdose have recently interacted with the health care system, which represents an opportunity for intervention. In one analysis, 77% of people had contact with the health care system in the year before they died from overdose,[4] and nearly 40% had contact within a month.[5] Forty-five percent had previously sought treatment specifically for acute or chronic pain,[4] and the risk of subsequent fatal overdose increases in those who present to the emergency department with a nonfatal overdose.[6] Currently, the role of recent surgery in patients who present with opioid overdose is unknown but may represent an opportunity to identify those at risk and to intervene.

We aimed to characterize the frequency of health care encounters for surgery, pain, or prior overdose within the preceding 24 months in patients who presented to Providence Health Care emergency departments with an opioid overdose. We hypothesized that most patients in our cohort would have had health care encounters in the 24 months prior to opioid overdose, which may represent an opportunity for intervention.

Methods

This retrospective, observational cohort study was conducted with approval from the University of British Columbia Clinical Research Ethics Board (approved 22 July 2019; H19-02011) and the Providence Health Care Information Access and Privacy Office.

Study population

We included all patients who presented to Providence Health Care emergency departments (St. Paul's Hospital or Mount Saint Joseph Hospital) with an opioid overdose over a 12-month period (1 July 2018 to 30 June 2019). This period was chosen to provide continuity with the 2017 data presented in a previous analysis of opioid overdose deaths in Vancouver.[4] We excluded non-opioid-related overdoses (e.g., alcohol, cocaine), presentations for substance use and/or misuse that did not result in an overdose, and those that did not meet the Providence Health Care definition of an overdose, which required a coded chart diagnosis of "heroin overdose/intoxication," "other opioid overdose/intoxication," or "recreational drug overdose not otherwise specified." Overdose events were further confirmed by the presence of either "opioid overdose" or "use of naloxone (resulting in reversal of overdose)" in the medical record. If a patient had multiple overdoses during the study period, we used the most recent event.

Data collection

We extracted available demographic data (including age, gender, and postal code) from the patient's electronic medical record. We identified health care system encounters for pain management or surgery within 24 months prior to the overdose event. When available, we identified details about prior surgery (specialty, invasiveness, type, and timing) prior to the overdose event.

We identified patients with a history of pain, as previously described in Vancouver Coastal Health's *Response to the Opioid Overdose Crisis in Vancouver Coastal Health* report.[4] A pain visit was defined as one in which the primary reason for the visit included pain or where pain was listed in the nursing notes or physician assessment as the primary reason for the visit, other than for chest pain. For example, if the diagnosis code was reported as "swelling/redness," the episode was included if pain was also listed as a primary complaint. We extracted information about the cause, type (acute or chronic), duration, and location of pain, and the highest rated severity (0–10). If more than one visit for pain was identified, we used the most recent visit but also noted other pain visits. Finally, we recorded the number of overdose presentations within the previous 10 years.

Statistical analysis

Data were described using percentages, means, standard deviations, medians, and interquartile ranges. We used a Fisher exact test (Social Science Statistics online calculator[7]) to compare the incidence and number of prior overdoses in patients with and without prior pain or surgery visits. Data presentation and analysis were conducted using Microsoft Excel version 16.57 (Microsoft Corporation, Redmond, WA) and Tableau version 12.1 (Tableau Software, LLC, Seattle, WA).

TABLE 1. Characteristics of patients presenting to Providence Health Care emergency departments with an opioid overdose, stratified by health care encounter, July 2018 to June 2019.

Patient characteristics		Overall cohort N = 1104	Prior visit for pain or surgery N = 556	No prior visit for pain or surgery N = 548
Fatal overdose, n (%)		4 (0.4%)	1 (0.2%)	3 (0.5%)
Age (years), mean (SD)		41 (12)	41 (12)	39 (13)
Gender, n (%)	Male	854 (77%)	428 (77%)	426 (78%)
	Female	241 (22%)	124 (22%)	117 (21%)
	Nonbinary or transgender	9 (1%)	4 (1%)	5 (1%)
No fixed address, n (%)		418 (38%)	214 (39%)	204 (37%)
Out-of-province postal code in chart, n (%)		11 (1%)	3 (0.5%)	8 (2%)

Results

Population characteristics

We identified 1104 patients who presented to Providence Health Care with an opioid overdose, with a mean age of 41 (SD = 12); 77% were male (n = 854). Few data on population characteristics were missing (< 5%) except for postal code and type of pain (acute or chronic), which were missing in 38% and 24% of patients, respectively.

The characteristics of patients with and without prior health care encounters for pain or surgery were similar **[Table 1]**. The geographic distribution of opioid overdose patients who presented to Providence Health Care is shown in **Figure 1**; 38% did not have a fixed address. During the study period, the highest numbers of overdose presentations occurred in March and June 2019 **[Figure 2]**.

Health care encounters for pain or surgery prior to overdose

Within the 24 months prior to the overdose event, 50% (547/1104) of the cohort had a health care encounter for pain and 5% (56/1104) presented for surgery or a surgical procedure. Among those who had a health encounter for pain and/or surgery, 79% (437/556) of these occurred within 12 months of the event (437/1104 = 40% of the cohort) **[Figure 3]**.

Surgical encounters

Among patients who had surgery within 24 months prior to their overdose, 25% (14/56) had multiple procedures. Most surgeries (88%) were minor. The most common procedures were endoscopy (30%) and orthopedic surgery (38%) **[Figure 4]**. Of those who had surgery within 24 months of their overdose, 84% (47/56) had also visited a Providence Health Care facility for pain.

Pain-related encounters

Pain-related encounters within the 24 months prior to an opioid overdose were typically recurrent, with 39% of patients (215/547) having more than one pain visit during that period (it is unknown if visits were related). The most common complaint

FIGURE 1. Geographical distribution of patients experiencing opioid overdoses presenting to Providence Health Care emergency departments.

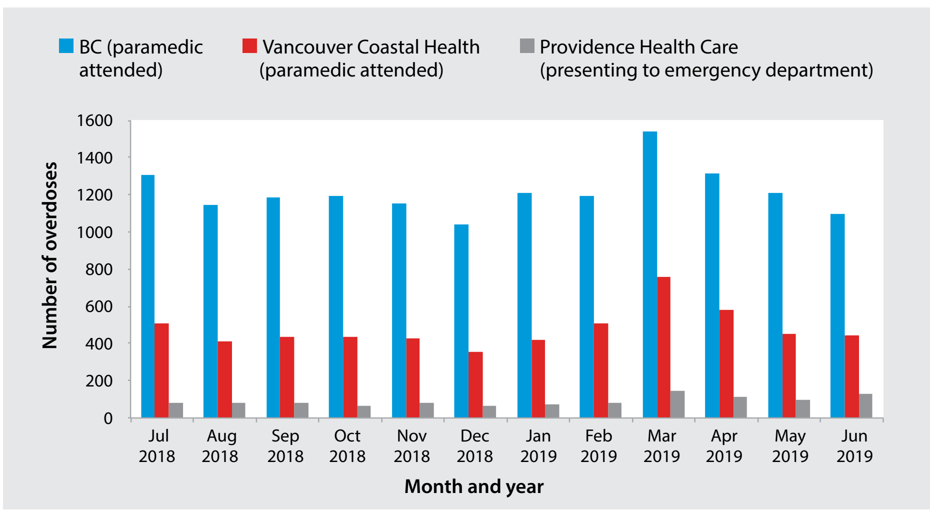

FIGURE 2. Monthly opioid overdose presentations at Providence Health Care emergency departments (data from this study) compared with overall BC and Vancouver Coastal Health paramedic-attended overdoses, July 2018 to June 2019.

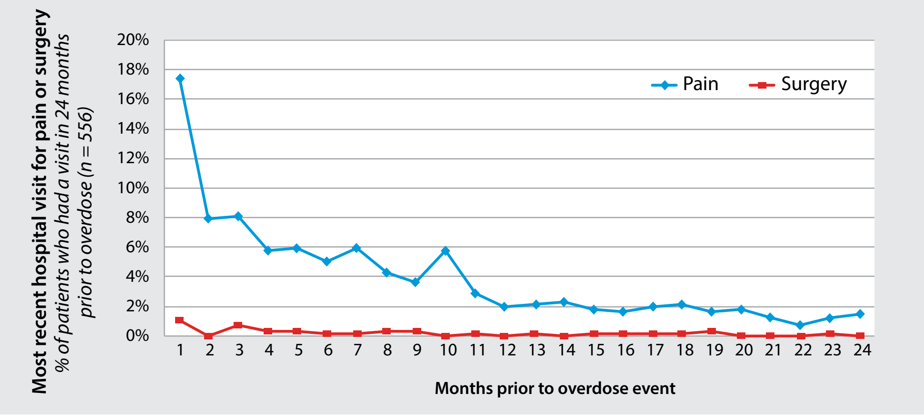

FIGURE 3. Months from health care encounter to opioid overdose in population that had previous pain or surgery visits.

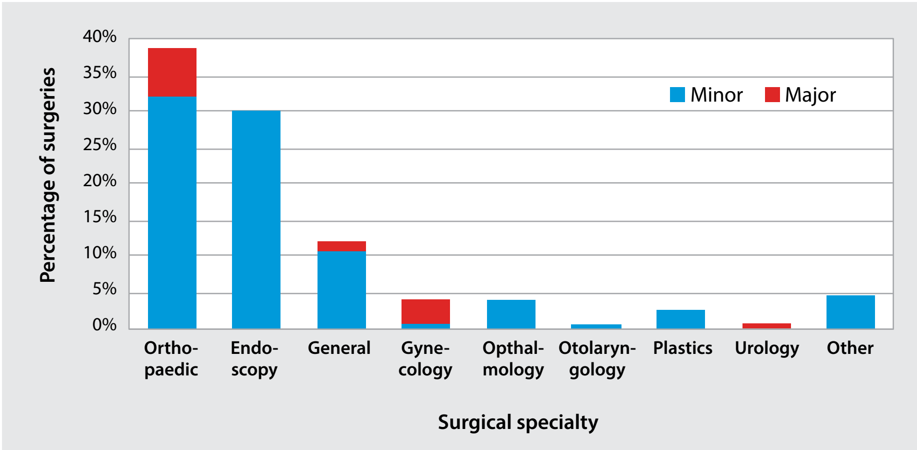

FIGURE 4. Type of surgical encounter, stratified by invasiveness.

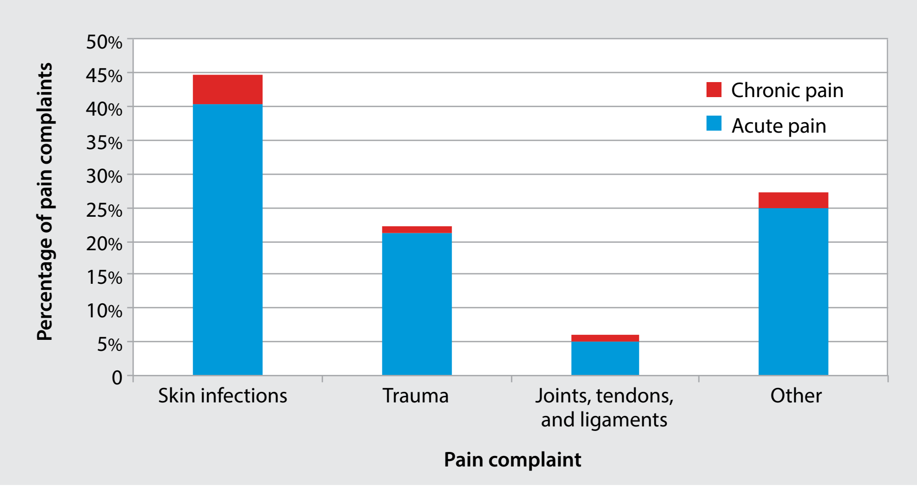

FIGURE 5. Health care encounters related to pain, stratified by duration, type (acute or chronic), and main complaint.

Skin infections include cellulitis, limb infection, and redness/swelling. Trauma includes assault, fracture, and laceration. Joints, tendons, and ligaments include joint separation or effusion, ligament or tendon tears, injuries, and inflammation. Other includes postoperative, abdominal/bowel, back, drug injection/ingestion, eye/ear/dental, fall, head injury/headache, withdrawal, and gynecology.

TABLE 2. Patient history of previous overdoses within prior 10 years of index overdose event, stratified by health care encounter.

Patient overdose history	Overall cohort N = 1104	Prior visit for pain or surgery N = 556	No prior visit for pain or surgery N = 548	*P**
Previous overdose, n (%)	626 (57%)	367 (66%)	259 (47%)	< .00001†
- Number of previous overdoses, median (interquartile range); range	2 (3); 1–28	3 (4); 1–28	2 (2); 1–25	–
- Number that had > 1 previous overdose, n (%)	404 (65%)	260 (71%)	149 (58%)	.0006†

*Fisher exact test, †$P < .05$

was pain due to a skin infection such as cellulitis, swelling and redness, or an arm or leg infection; most were acute **[Figure 5]**.

Prior overdose events

More than half the cohort (57%, 626/1104) had presented to a Providence Health Care emergency department with a prior overdose, and multiple overdoses were more common in those who also had previous visits for pain or surgery **[Table 2]**. Those patients who had prior health care encounters for pain or surgery were more likely to have had a prior overdose than those who did not have an encounter (66% vs 47%; 367/556 vs 259/548) ($P < .00001$). Furthermore, among those who had a previous overdose event, there was a significant association between having prior pain or surgery visits and having multiple prior overdoses ($P = .0006$).

Discussion

Our results indicate that people who present with an opioid overdose have frequently interacted with the health care system for pain, surgery, or prior overdose in the 24 months leading up to their event. Furthermore, people with previous health care encounters are also more likely to have experienced recent nonfatal overdoses compared with those with no recent health care encounters. Our findings highlight multiple opportunities to identify those patients at risk for subsequent opioid overdose and potentially intervene to reduce harm and promote health in this vulnerable population.[5,6] In particular, opioid management for patients presenting for surgery or acute pain episodes represents a strategic opportunity.

Consistent with our results, a previous study found that 54% of the BC Provincial Overdose Cohort visited the emergency department in the year before their overdose, compared with 17% of the controls.[5] However, our study cohort contained more people who had no fixed address (38%) than reported by the BC Provincial Overdose Cohort (17%),[1] which may reflect the unique vulnerabilities of our specific population. Similar to the BC Provincial

Overdose Cohort, the proportion of our cohort that had no fixed address included more males and younger patients than the proportion that had a listed address.[1]

Our results are particularly relevant given that BC has the highest numbers and rates of opioid overdose events and related deaths in the country,[8] which have been further compounded by the COVID-19 pandemic.[9] There is often a complicated relationship between people suffering from pain (chronic or acute) and opioid use or misuse.[4] People are more open to behavior change in times of transition or life health events,[10] including interactions with the health care system for surgery and pain management. The frequent visits for pain management for skin infections that we identified in our study are not unexpected, given that our cohort included a high proportion of people who injected drugs and thus were at increased risk for skin and soft tissue infections.[11,12] In addition, recent nonfatal overdoses are a clear indication of increased risk for subsequent overdoses, both nonfatal and fatal.[13]

Patients at risk for opioid use disorder face specific challenges regarding the time of surgery or pain management for several reasons, including tolerance of traditional opioid medications and opioid-induced hyperalgesia.[14,15] Moderate to severe pain and inadequate pain management may play a role in the development of persistent postoperative pain.[16] A previous study found that most patients with nonfatal opioid overdoses had filled an opioid prescription within 6 months prior to the event.[13] Our study cohort most commonly underwent relatively minor surgery, which would not typically require large doses of postoperative opioids.

To prevent further harm and future overdoses in this vulnerable population, every health care interaction should be seen as an opportunity to intervene. Many emergency departments, including at Vancouver General Hospital, are now initiating buprenorphine/naloxone when patients present with adverse effects of opioid use.[17,18] The more widespread use of buprenorphine microinduction has made this possible because patients can be started on low-dose buprenorphine/naloxone at presentation without first withdrawing from full opioid agonists and without precipitating withdrawal.[19,20] This requires direct referral to a community site or the patient's primary care provider the following day to continue treatment. Inpatients can also be initiated on opioid agonist therapy while in hospital if the patient is motivated.[21,22] When patients with opioid use disorder or chronic opioid use present for surgery or pain management, their stage of change should be explored, and a referral to addiction medicine, if available at that centre, should be considered if the patient is contemplative or prepared to change. If an addiction medicine service is not available at the centre, the patient should be directed to speak with their family physician and to supportive resources in the community to facilitate interventions in those patients who are ready to consider making a change. Health care providers in the emergency and surgical wards could be trained in brief motivational interviewing for substance use to help patients make changes.[23,24] All patients who use opioids and have other risk factors should be provided with a naloxone kit for opioid overdose.[25,26] Given that most of the patients in our cohort had most often presented for endoscopy or orthopaedic surgery, those units could consider having naloxone kits available to distribute to all patients upon discharge.

Several strategies and recommendations have been proposed to reduce the risk of postsurgical chronic pain and persistent opioid use. Multidisciplinary Transitional Pain Clinic services have been implemented in Canada, including recently at St. Paul's Hospital and Vancouver General Hospital, to identify patients who are at high risk of complex postoperative pain as early as possible and to provide a customized pain management strategy perioperatively and opioid taper once the patient is discharged from hospital.[27] Family physicians are also a key support for high-risk patients following discharge, particularly when a Transitional Pain Clinic is not available. Recommendations and best practices from Choosing Wisely Canada that are relevant to chronic and perioperative pain and opioid management are summarized in **Table 3**,[28-32] and the optimal durations of opioid prescription after specific subtypes of surgery are

TABLE 3. Recommendations for perioperative opioid and chronic pain and symptom management.[28-32]

Recommendation	Year	Source
Prolonged use of opioid analgesia beyond the immediate postoperative period or other acute pain episode is not recommended.	2022	Choosing Wisely Canada: Canadian Association of General Surgeons[28]
Do not continue opioid analgesia beyond the immediate postoperative period or other episode of acute, severe pain.	2022	Choosing Wisely Canada: College of Family Physicians of Canada[29]
Do not routinely discontinue buprenorphine perioperatively or in the context of acute pain requiring additional opioid analgesia.	2022	Choosing Wisely Canada: Canadian Society of Addiction Medicine[30]
Do not initiate or escalate opioid doses for chronic noncancer pain before optimizing non-opioid pharmacotherapy and nonpharmacologic therapy.	2021	Choosing Wisely Canada: Canadian Society of Hospital Pharmacists[31]
Do not use opioids without considering opioid sparing strategies and multimodal analgesia in patients after injury.	2021	Choosing Wisely Canada: Trauma Association of Canada[32]
Do not routinely prescribe benzodiazepines or other sedative-hypnotics for promotion of sleep without a trial of nonpharmacologic interventions.	2021	Choosing Wisely Canada: Canadian Society of Hospital Pharmacists[31]

TABLE 4. Optimal length of opioid pain medication prescription after common surgical procedures for opioid-naive patients.[33]

Surgical category	Optimal length of opioid prescription
General surgery procedures	4–9 days
Breast and gynecologic procedures	4–13 days
Orthopaedic and spine procedures	6–15 days

outlined in **Table 4**.[33] Comprehensive recommendations for managing patients with concurrent pain and opioid use disorder in primary care, including diagnosis, risk factors, opioid tapering, and induction of buprenorphine, are available from the BC government.[34,35]

Study limitations

Our study has several limitations, including those that are inherent to a retrospective chart review, such as incomplete or missing data. Our data were collected from a single provincial health authority, which may not be generalizable to other centres or provinces. We were also unable to determine interactions outside of Providence Health Care, which may have underestimated the frequency of interactions. Our definition of encounters for pain was used in previous studies but may not have fully captured this complex phenomenon. Furthermore, we relied on information for people who had overdosed but survived to the emergency department and did not capture those people who died prior to reaching hospital. Importantly, we were unable to identify risk factors for overdose after pain or surgical health care encounter because our study did not contain a control group of patients who had not overdosed; this is a critical area for future study. In addition, given the observational nature of our study, we cannot determine whether recent surgery or pain directly resulted in an opioid overdose.

Conclusions

Our study supports local evidence that people who present with opioid overdose have frequently had health care encounters within 12 to 24 months prior to the event.[4] Our study also provides a novel description of this vulnerable population presenting to our hospital system with an opioid overdose and indicates that recent encounters with the health care system for either surgery or pain are common prior to overdose. Our results further identify an additional opportunity to intervene in this population.

Our results indicate that people who present with an opioid overdose have frequently interacted with the health care system for pain, surgery, or prior overdose in the 24 months leading up to their event.

Future research should focus on identifying effective interventions and explore the relationship between surgery, postoperative opioid use, and subsequent overdose. ■

Competing interests
None declared.

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FAQs about expedited surgeries and billing the expedited surgery premium

What is an expedited surgery?
A surgery is considered "expedited" if it is performed within 40 business days from the date a surgeon receives written approval for surgery from a WorkSafeBC board officer.

It is important for surgeons to mark this date in Teleplan by invoicing for fee code 19326 and using the approval date as the service date.

What is the expedited surgery premium (ESP)?
The ESP is a surcharge that is paid in addition to the applicable MSP fees when a surgeon performs a surgery for an injured worker covered by WorkSafeBC within a certain time frame. It is not billed separately from the surgery.

This article is the opinion of WorkSafeBC and has not been peer reviewed by the BCMJ Editorial Board.

The ESP is automatically applied to surgery payments for surgeries that are billed through Teleplan and follow the process and timelines shown in the **Figure**. Surgeons may bill WorkSafeBC for multiple procedures in a manner consistent with the current practice of billing MSP for multiple procedures.

How do you qualify a surgery for the ESP?
The **Figure** shows the process for seeking approval for a surgery and subsequently qualifying that surgery for ESP.

What if an injured worker declines a proposed surgery date?
If an injured worker declines the surgery date and requires a rescheduled date outside of the 40-business-day window for a surgery that originally qualifies for the ESP, the surgeon can request an exception by calling WorkSafeBC's Health Care Programs department at 1 866 244-6404 and pressing "2" or by emailing hcsinqu@worksafebc.com.

What if I forget to bill fee code 19326?
If fee code 19326 is *not* billed, qualification for the ESP will rely on the submission of fee code 19911, 19912, or 19908 via Teleplan. WorkSafeBC will use the latest of its service dates to mark the start of the 40-business-day ESP qualification period.

What if it is an emergency or trauma surgery where prior surgical approval cannot be obtained from WorkSafeBC?
If an emergency or trauma surgery has been performed, the surgeon will submit the prescribed Authorization Request for Surgery (Form 83D6) within 5 business days following the surgery to the WorkSafeBC board

Continued on page 28

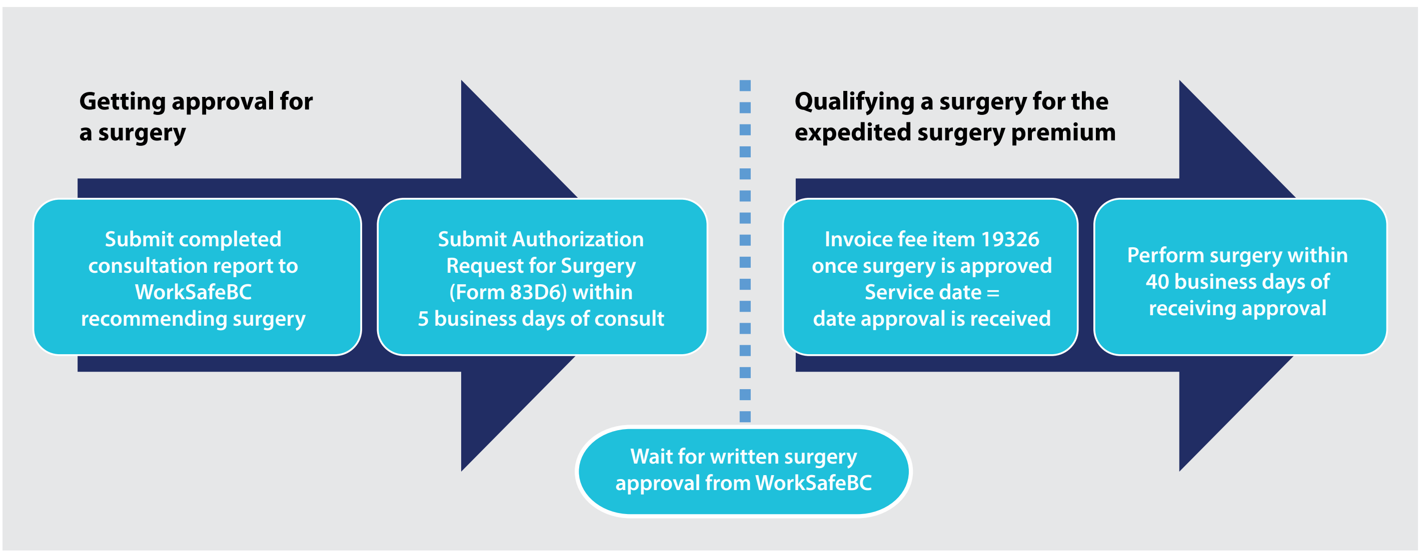

FIGURE. Getting approval for a surgery and qualifying that surgery for the expedited surgery premium are two separate processes.

Avian influenza: A BC clinician's guide to diagnosis and management

Highly pathogenic avian influenza (HPAI), notably of the H5N1 subtype, was detected in domestic poultry across BC and around the globe at unprecedented rates in 2022.[1-3] BC has had the highest number of poultry premises affected in comparison to other provinces,[1] leading to significant impacts on the livelihoods and well-being of poultry owners.

Avian influenza viruses have sporadically infected humans and have largely followed direct exposure to infected poultry.[4] The rising detection among birds increases the potential for human exposure and intermixing of different influenza strains.[4] Human health risk is currently considered to be low. However, if the virus adapts and leads to sustained human-to-human transmission, this would be considered a high-impact event.[4] Early detection of avian influenza viruses in humans enables public health action to detect and control potential human-to-human transmission.

Clinical presentation

Clinical signs and symptoms of avian influenza in humans closely resemble acute respiratory or influenza-like illness. Disease severity and manifestations can range from asymptomatic infection to severe.[5] Avian influenza viruses in circulation have an incubation period in humans of 2 to 10 days (with most averaging 2 to 5 days).[5]

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

Who to test for avian influenza and report to public health

Clinicians should have a low threshold for testing patients presenting with symptoms compatible with avian influenza and who have had close contact with an infected/sick bird or animal or other concerning exposures[5] within 10 days following that exposure. These symptomatic individuals should be reported to your local Medical Health Officer as soon as possible.[5]

How to collect specimens for avian influenza testing

When testing is indicated, a nasopharyngeal swab and a throat swab or sputum sample (for patients with a productive cough) should be collected.

Notify the BCCDC medical microbiologist on call of the suspect case and testing request at 604 661-7033. Collect the sample and document the exposure on the test requisition (e.g., human high-risk HPAI), and send it directly to your local testing lab.

Recommendations for management of HPAI exposure in humans

If asymptomatic

Provide instructions to self-monitor for the development of symptoms for 10 days after the last exposure, and report any symptom development immediately to local public health. Individuals should also be counseled to avoid visiting other farms, avoid interactions with individuals at higher risk of severe illness,[5] and avoid large gatherings for 10 days following exposure.

Individuals can be provided chemoprophylaxis for the purposes of protecting the individual and preventing further transmission. It can be given up to 7 days after the last exposure. Decision to offer prophylaxis should be based on clinical judgment and an exposure assessment. Exposure assessment should consider the use of personal protective equipment and whether any breaches occurred, the type of exposure (working directly with affected birds, working with birds with confirmed infection, open/closed air environment), the duration/time since exposure, and the risk of complications from influenza.[5]

If symptomatic

Antivirals should be considered for the treatment of both suspected and confirmed cases of avian influenza, as they can reduce the severity and duration of illness if administered within 48 hours of illness onset. The person should be advised to follow respiratory etiquette, wash hands regularly, and isolate from others for 7 days or until symptoms resolve, whichever is longer.

If household contacts develop symptoms before test results are available, they should also isolate and notify their local public health unit.

If the decision is made to provide chemoprophylaxis for contacts, oseltamivir 75 mg b.i.d. can be given for 7 days (for time-limited exposures) or 10 days (for ongoing exposures) in adults. Treatment of suspected or confirmed cases requires only a 5-day course. Alternate to oseltamivir could include zanamivir 10 mg b.i.d.[6]

What patients can do to protect themselves

Actions that people can take (particularly those handling birds and/or with small flocks) to protect themselves and others are

provided in the interim BCCDC clinical guidelines.[5] To prevent co-infection with both seasonal human influenza and avian influenza viruses, it is important patients are offered the annual influenza vaccine. ■

—Rohit Vijh, MD, MPH, CCFP
Senior Public Health and Preventive Medicine Resident, UBC
Community Family Physician

—Erin Fraser, DVM, MSc
Public Health Veterinarian, Public Health Response, BC Centre for Disease Control

—Mayank Singal, MD, MPH, CCFP, FRCPC
Physician Epidemiologist, Public Health Response, BC Centre for Disease Control

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Continued from page 26

officer along with the comprehensive consultation report. The surgeon should also bill fee code 19326, using the surgery date as the date of service. If the claim is accepted, the ESP will be paid.

Can I use different payee numbers to invoice for the consults (or fee code 19326) and the surgical procedure fee items?
No. You must invoice using the same payee number via Teleplan.

I've been paid for the surgery, but I did not receive payment for the ESP. What happened?
If you received payment for a surgery without receiving the ESP surcharge at the same time, this likely means the surgery did not qualify for the ESP. The ESP surcharge is paid only at the time the surgery's base fees are paid. You will not be paid the ESP separately later. If you wish to dispute an unpaid ESP surcharge, please contact WorkSafeBC Payment Services promptly at 1 888 422-2228.

If you are unsure whether you were paid the ESP for a surgery, try checking for it in your medical billing software under "Adjustment Code 31."

Are there exceptions to the ESP program?
Joint replacement surgery is an exception to the 40-business-day rule. The ESP qualification window for this procedure is 6 calendar months. For the ESP to be applied to the surgery, the surgeon needs to call WorkSafeBC Health Care Programs at 1 866 244-6404 and press "2" or email hcsinqu@worksafebc.com.

If you encounter other challenges or have further questions regarding ESP billings, contact Doctors of BC at worksafebc@doctorsofbc.ca. ■

—Patrick Wong
Quality Assurance Supervisor, WorkSafeBC

—Dana Chmelnitsky
Program Manager, WorkSafeBC

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Obituaries

We welcome original tributes of less than 700 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 Mary-Wynne Ashford (née Moar) *1939–2022*

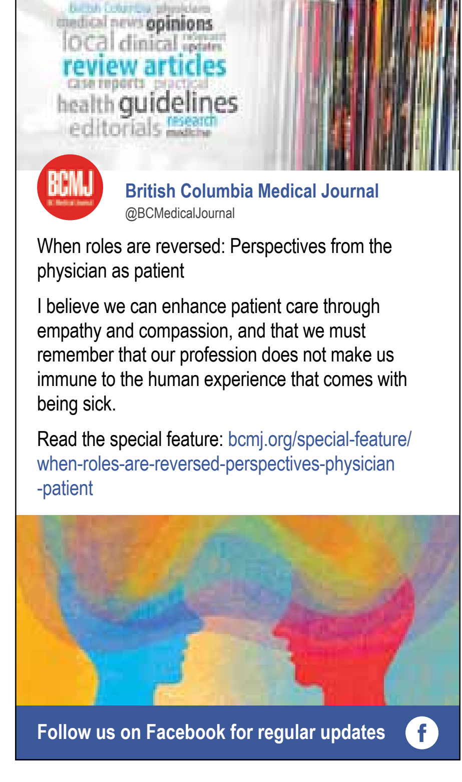
Dr Mary-Wynne Ashford was born on 17 March 1939 in Indian Head, Saskatchewan. She passed away peacefully on 19 November 2022 in Victoria, British Columbia, with family at her side. A retired family and palliative care physician in Victoria and retired associate professor at the University of Victoria, Mary-Wynne was adamant that a physician's role went far beyond caring for individual patients. She believed that advocating for peace and the elimination of nuclear weapons was part of a doctor's duty of care.

For 37 years Mary-Wynne wrote and spoke internationally about peace and disarmament. She was co-president of International Physicians for the Prevention of Nuclear War (IPPNW) from 1998 to 2002 (which won the Nobel Peace Prize in 1985) and president of Canadian Physicians for the Prevention of Nuclear War from 1988 to 1990. She led two IPPNW delegations to North Korea, in 1999 and 2000. Her award-winning book, *Enough Blood Shed: 101 Solutions to Violence, Terror and War*, has been translated into Japanese and Korean. She won many awards, including the Queen's medal on two occasions, the Gandhi Peace Prize in 1997, the Dr Cam Coady Medal of Excellence from Doctors of BC in 2019, and, with Dr Jonathan Down, the 2019 Distinguished Achievement Award from Canadians for a Nuclear Weapons Convention. She recognized the vital role of women as peace activists and in 2018 joined 1200 women from around the world to walk across the Reunification Bridge to a peace park in the demilitarized zone between North and South Korea. In 2021 she developed and taught an online course, Global Solutions for Peace, Equality, and Sustainability, sponsored by Next Gen U and IPPNW Canada. She nurtured an extensive network of international connections, and her ability to form strong relationships was a hallmark feature of her character.

The third of four children born to Jack Moar (a bush pilot, inventor, and entrepreneur) and Kitty Moar (a writer, teacher, artist, and community organizer), Mary-Wynne inherited a sense of boundless energy and optimism, and the belief that she had no limits. She was clever and confident, and she connected with people in a deep and meaningful way. At the University of Alberta, she earned a BSc in home economics and a BEd. In 1981 she graduated from the University of Calgary as a doctor of medicine, and in 1997 she earned her PhD in education from Simon Fraser University.

She married the late Dr David Ashford and was the mother of three (Karen, Graham, and Patrick). As a volunteer with the Calgary Zoo, she was foster mother to two baby orangutans and a polar bear cub, capturing the activity of those years in a regular column for the *Calgary Herald* titled "Out of My Tree." Before enrolling in medical school, she studied music theory, singing, French, creative writing, and Shakespearean theatre. After completing her medical training and moving to Victoria, she married Dr Russell Davidson, adding four stepchildren (Katyann, Victoria, Gillian, and Emma) to the warm circle of family. She was grandmother to 10 grandchildren.

A passion for the arts infused her life. She performed in many drama and theatre productions, and her involvement in the Gettin' Higher Choir and the Community



Choir Leadership Training program continued until her death. She was renowned for her sewing skills, especially her handcrafted puppets. Recently she created puppets representing famous female social activists for the University of Victoria Faculty of Education and several special therapy puppets used to assist Syrian refugee children in telling their stories and settling in more easily in Canada.

For decades, Mary-Wynne collaborated with members of the Bahá'í Faith on issues of global peace, prosperity, and the advancement of women. In 2008 she formally joined the Bahá'í Faith and was an active member of the community, serving on institutions and promoting the teachings, particularly those that elaborated on aspects of world peace and global governance.

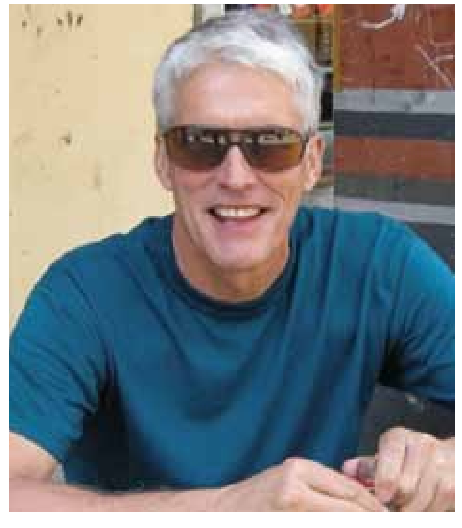
Mary-Wynne never lost hope that the world would one day be nuclear weapons–free. She was one of the most inspirational and influential leaders of our time.

—Jonathan Down, MD, FRCPC
Victoria

Dr Ruth Oliver
1946–2022

Ruth passed away peacefully in her sleep at age 76. Her love of family and faith remained till the end. Born in South Africa, she was predeceased by her father, James, and mother, Mary. She is survived by her daughters, Tamara (Damian) and Adrienne (Graziano); grandchildren, Amayah, Xavier, Lucy, and Irie; and seven siblings. Ruth graduated from medical school in Durban, South Africa, in 1972 and then immigrated to Canada, where she completed her residency in psychiatry at Queen's University in Kingston in the late 1970s. Most of her professional career was spent in outpatient practice in the Lower Mainland. She retired in 2009. She was a brilliant, skilled, compassionate, and dedicated physician, loved by her patients and colleagues. She often used her many creative talents to help the less fortunate, including baking for her local soup kitchen, making blankets for homeless shelters, and providing flower arrangements for her church using flowers from her own beautiful garden. She will be deeply missed, but we're grateful for her towering example. In lieu of flowers, please consider a donation to Covenant House (www.covenanthousebc.org), which supports young people facing homelessness, a cause near and dear to Ruth's heart.

—Adrienne Melck, MD
Vancouver



Dr C. Paul Sabiston
1954–2022

Dr Paul Sabiston died on 8 November 2022, with the help of medical assistance in dying, after 7 years of living with the effects of bladder cancer and its treatment. He was at home with his family, pragmatic to the end.

Paul graduated from the University of Ottawa medical school in 1979 and started his residency in orthopaedics at Vancouver General Hospital that year, where we were colleagues. He was not only a gifted student, but also an amazing athlete, having swum for UBC (national team trials), and a bicycle racer, completing numerous Gastown Grands Prix.

He told me he couldn't run but, despite this modesty, was first out of the water in both the Vancouver and Victoria triathlons, finishing in the top four in each race.

Following residency Paul spent a year in Calgary doing research and knee surgery, with a faculty appointment waiting for him at UBC. Luckily I was able to convince him to come to Lions Gate Hospital, where he formed the nucleus of a strong orthopaedics team, which continues to be a centre of excellence well after his retirement in 2014.

Paul worked hard and was loved by his patients, colleagues, and nurses alike. He kept a good work-life balance, spending much of his spare time foil-kiting in the summer and snowboarding and skiing in the winter. He was very skilled at all

these activities. On one occasion, he and an equally talented friend paddled a twin surf kayak around all the Bowron Lakes between sunrise and sunset. He didn't recommend this activity to me, as his subsequent wrist tendonitis slowed down his surgery for the next week!

We have lost a talented knee surgeon and a good friend to all.

—Denis Morris, MD, FRCSC
West Vancouver

NEW ARTICLE TYPE:

BC Stories

Have you heard the story about the cardiologist who came across a cougar while fly-fishing in Bella Coola? Or the pediatrician who drove from White Rock to Whitehorse to meet the brother she had been separated from at birth? No? Well, neither have we—but we want to. We're introducing a new type of article and we need your stories.

BC Stories is where you can share a personal story unrelated to practising medicine. It can be funny, topical, sad, perplexing, or just plain interesting; it can relate to the arts, humanities, BC travel, sports, or anything else you're passionate about. Stories should be written in a casual, informal tone, take place in British Columbia, and be 1000–2000 words in length. Include high-resolution photos or other images when possible.

bcmj.org/submit-article

Questions?
Email journal@doctorsofbc.ca

Resources for emerging and persistent infectious diseases

Infectious diseases in the British Columbian population during 2022 have posed major challenges to the health system. Keeping abreast of emerging and persistent infectious diseases is crucial, and the following may be helpful information tools.

DynaMed, available through the College Library, classifies point-of-care information by specialty. Browse the infectious diseases section (or search by keyword) for a wide scope of subtopics, such as hemorrhagic fevers and fungal, prion, and viral infections.

Similarly, *BMJ* Best Practice displays evidence-based guidance in over 550 infectious diseases modules in a list for browsing; it is also keyword searchable. Comorbidities can be flagged to focus content on that most relevant to your patient's concurrent health conditions.

Both Best Practice and DynaMed are available online via www.cpsbc.ca/registrants/library/point-care-tools or as apps at www.cpsbc.ca/registrants/library/mobile-apps.

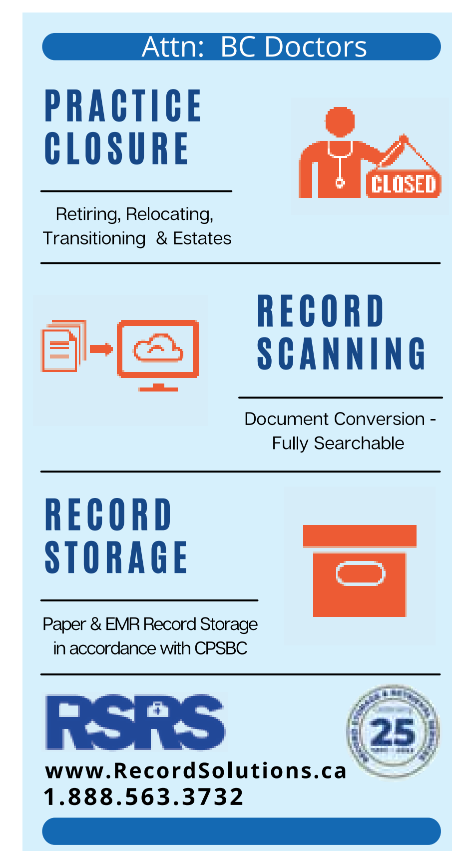
Current books on infectious diseases are an important part of the College Library's collection. Library users can search the catalogue (https://szasz.catalogue.libraries.coop) and view such communicable diseases e-books as:

- *Review of Medical Microbiology and Immunology: A Guide to Clinical Infectious Diseases*, 2022
- *Cardiovascular Complications of COVID-19: Risk, Pathogenesis and Outcomes*, 2022
- *Atlas of Dermatology, Dermatopathology and Venereology: Cutaneous Infectious and Neoplastic Conditions and Procedural Dermatology*, 2021
- *Highly Infectious Diseases in Critical Care: A Comprehensive Clinical Guide*, 2020
- *Hunter's Tropical Medicine and Emerging Infectious Diseases*, 2020

Valuable sources of infectious diseases clinical guidance and epidemiology are available from the BC Centre for Disease Control (www.bccdc.ca) and the Public Health Agency of Canada (www.canada.ca/en/public-health.html). Also, the CMA Joule CPG Infobase (https://joule cma.ca/cpg), a directory of Canadian clinical guidelines, lists over 550 guidelines on infectious diseases published in the last 5 years. ■

—Karen MacDonell
Director, Library Services

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.



Classifieds

NEW PRICING: As of this issue, there will be a two-tier pricing structure for classified ads. Advertisers have the option to run an ad online-only at our current monthly rates, or pay a $25 per-month surcharge for an ad to be included in a print issue as well as online. **Online 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 January for February 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.

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The Sow's Ear Medical Clinic is looking for physicians to join our family practice. We are a busy multiphysician clinic with an on-site lab and adjoining pharmacy. This is a great opportunity to join an established clinic with a built-in patient panel or to start your own patient panel in a new location! The clinic is located in Lantzville, just outside of Nanaimo on Vancouver Island. This prime location means you can enjoy an oceanfront village feel with the comforts of big city amenities only minutes away. Multiple openings available: start your own practice

immediately or take over an existing practice in June 2023. For more information, contact Vicky Smith at sowsear-docs@shaw.ca.

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RICHMOND—HOSPITALIST
The Richmond hospitalist group is looking for hospitalists to join our group. Previous experience is an asset but we are happy to mentor new grads as well. Flexible scheduling based on 7 days' work commitment. Contact David at david.li2@vch.ca for more information.

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VANCOUVER—PRACTISE THE WAY YOU WERE TAUGHT, EARN WHAT YOU DESERVE
Harrison Healthcare is a team-based primary care centre that offers personalized, service-focused care. Founded by Don Copeman, we have a strong culture focused on compassion, innovation, and overall excellence. Although we attract patients that require complex care, our focus is on prevention and early detection, which makes for nicely balanced practices. We are looking for outstanding, personable family physicians with strong collaboration skills. We offer a generous compensation package with no overhead costs and an exceptional work environment. Please send your CV to careers@harrisonhealthcare.ca and visit us at www.harrisonhealthcare.ca.

VICTORIA—HOSPITALISTS
The South Island Hospitalists group is looking for hospitalists to join our dynamic team in beautiful Victoria. Hospitalists in Victoria provide a 24-hour MRP service at the Victoria General and Royal Jubilee Hospitals. There is a lot of variety and pathology, and we enjoy a high degree of autonomy while being well supported by our specialist colleagues. Our care covers patients aged 17 to 100+ and includes addictions, palliative care, geriatrics, and comanagement of surgical and rehabilitation patients. Qualifications include CCFP/equivalent or FRCPC (internal medicine), eligible for CPSBC, ACLS; hospital experience an asset. Contact

Shannon Williams at medstaffrecruitment@islandhealth.ca.

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CME calendar

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Hope for change

Hope is on the decline, just when it's needed all the more.

Tej K. Khalsa, MD, MSc, FRCPC

British Columbians are outpacing the rest of Canada in a decline in hopefulness.[1] In 2021–2022, 64% of people in Canada were hopeful about the future, down from 75% in 2016. The nation's 11% decline in hopefulness has been outmatched by British Columbia, where people have experienced a more marked decline of 14%.

The findings are troubling. Hope is part of a long, healthy, and meaningful life. Multiple large studies[2-4] with longitudinal follow-up have shown that hope is associated with a 30% to 40% lower mortality. The hopeful engage in healthier behavior.[5] The hopeful manage, reduce, or eliminate stressors, while those with lower hope ignore, avoid, or withdraw from the world.[6] The hopeful mobilize for social justice with cries of "Sí se puede!"[7] (Cesar Chavez) and "Yes we can!"[8] (Barack Obama).

A large body of literature has shown that discrimination is associated with negative mental health outcomes, including hopelessness. To quote Dr David R. Williams,[9] creator of the Everyday Discrimination Scale, "those little indignities are killing us."[10]

The power of such casual cruelty became chillingly clear to me the night I volunteered for a van ride through Vancouver's Downtown Eastside. As a med student, it felt gratifying to be handing out clean needle kits and condoms to a warm chorus of "Thank you!" and "Have a good night!" At one intersection a tall solitary figure stood on the edge of the cold curb—a transgender woman. She was so kind, we lingered and chatted for a few minutes from inside our heated van. As we slowly drove away from her, the van's driver whispered that she had worked hard to get into a retail job in a Vancouver department store. But her hope of safe employment was short-lived. She was so mercilessly bullied by other employees she quit and returned to sex work. Ten years later, it's no surprise to me that the vast majority of transgender and nonbinary people do not feel hopeful about the future.[1]

In my mind-body medicine practice at the Mayo Clinic,[11] and now in my home province of BC, I continue to tell my patients that we must decolonize our despair. When my patients tell me of their emotional exhaustion, how they feel worn out and weary from the world, I validate their feelings. I remind them that their feelings of defeat are a symptom of their loving heart, a heart that cares about a better future for themselves, others, and our world. That their feelings of defeat can be traced back to their north star—a guiding light to a world of justice, where each of us is free to embody the truth of who we are.

As Indigenous scholars[12] remind us, we are all relations. This winter season, may each of us rest and give our hopefulness meaningful replenishment, like connecting to caring community.[1] May we decolonize our despair to remember who we truly are: one human family. Hope for a better tomorrow, for every human being, depends on it. ■

Dr Khalsa is an educational consultant to the World Health Organization and an internal medicine specialist. She recently transitioned her practice of mind-body medicine from the Mayo Clinic to British Columbia.

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