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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 or submitted online at bcmj.org/submit-letter and must include your city or town of residence, telephone number, and email address. Please disclose any competing interests.

Re: Truth before reconciliation; humility before truth

Kudos to both the *BCMJ* and Dr Greggain for this heartfelt and inspiring President's Comment [*BCMJ* 2023;65:240-241]. Imagine if all in our profession acted in accordance with the principles outlined in this piece.

As for Dr Greggain, hearing reports of finding remains of Indigenous children on the grounds of the Kamloops residential school was gut-wrenching for me. I worked in Kamloops for 15 years at the

Urban Aboriginal Health Centre. Many of my patients had attended that school. I recall utter exhaustion at the end of one clinic day and the realization as I looked over our patient list with our clinic MOA that 18 of the day's patients were seen for medical issues related to posttraumatic stress disorder.

I want to submit that two additional Calls to Action from the Truth and Reconciliation Commission of Canada (#33 and #34) are also health related, even though they are captured under the "Justice" category, and should be included with the Calls

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Truth and Reconciliation Commission of Canada Calls to Action #33 and #34 (italics added by Dr Densmore)

33. We call upon the federal, provincial, and territorial governments to recognize as a high priority the need to address and prevent Fetal Alcohol Spectrum Disorder (FASD), and to develop, in collaboration with Aboriginal people, *FASD preventive programs* that can be delivered in a culturally appropriate manner.
34. We call upon the governments of Canada, the provinces, and territories to undertake reforms to the criminal justice system to better address the needs of offenders with Fetal Alcohol Spectrum Disorder (FASD), including:
 - i. Providing increased community resources and powers for courts to *ensure that FASD is properly diagnosed, and that appropriate community supports are in place for those with FASD*.
 - ii. Enacting statutory exemptions from mandatory minimum sentences of imprisonment for offenders affected by FASD.
 - iii. Providing community, correctional, and parole resources to maximize the ability of people with FASD to live in the community.
 - iv. Adopting appropriate evaluation mechanisms to measure the effectiveness of such programs and ensure community safety.

BOX. Truth and Reconciliation Commission of Canada Calls to Action #33 and #34.

www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf.

to Action that Dr Greggain drew our attention to [Box].

Calls #33 and #34 mean we as health care providers need to identify, diagnose, and appropriately support people with fetal alcohol spectrum disorder (FASD) and their families. We need to become FASD aware. When we diagnose people with FASD we can also learn about their family and their environment and can then recognize and advance opportunities for prevention. Prevention will require increased mental health and social support for birth mothers. Based on an estimate of 2400 federal jail inmates and 2400 provincial jail inmates, BC has approximately 4800 inmates; between 24% and 28% have FASD.¹ That is 1300 individuals. I have diagnosed about 14 incarcerated individuals with FASD in the last few years. Our clinic—currently the only clinic in BC that diagnoses adults with FASD—receives *no* sustainable funding from either the federal or provincial governments. More governmental support is required to meaningfully respond to Calls to Action #33 and #34. FASD is *not* a niche issue; FASD is diagnosed in 28% of foster and adopted youth referred to a children's mental health centre, 9% of children in special education programs, and 25% of children in foster care.¹

—Rod Densmore, MD
Medical Assessor, Adult FASD Clinic,
Independent Living Vernon

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Re: Does working part-time mean I've failed as a feminist?

Thank you, Dr Dunne, for sharing your experience as a feminist who is also a physician, managing your time in the modern world [*BCMj* 2023;65:277]. Your experience is shared by many, many others. There is still a real, measurable gender gap in opportunities. And, if the medical profession wants to address that, we need to make systemic change, not place the burden on

individuals to decide if they can act like they have it all.

It is time for our professional physician organizations to stop observing the differences¹⁻³ and instead make real change to remove the burden of sexism from individuals and replace the structures that created it in the first place.

I admire Anne-Marie Slaughter's work, but I wonder if Audre Lorde's wise words might not be the better source for women to draw on at this time: "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare."

Let's ask more of our profession and our peers to help solve these problems!

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

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Thank you, Dr Dunne, for sharing your experience [*BCMj* 2023;65:277]. I share so much of your experience and, with my children now being adults, admire your commitment to your values in your choices.

I wonder if a less binary question might be helpful? How does your decision to work part-time *support* the cause of feminism? Exercising choice might be the most important contribution any of us can make.

—Cecile Andreas, MD
Cranbrook

The revolution in primary care

It was just 6 years ago that the Ministry of Health embarked on a mission of transforming primary care and the concept of patient unattachment entered the health administration lexicon. Over the last 5 years, we as frontline health care providers have been subjected to the

machinations of a health ministry obsessed with unattachment.

Reflecting on the countless hours we have spent attending meetings and webinars sponsored by health authorities, divisions of family practice, Doctors of BC, and the Ministry of Health to address issues on how to accurately measure unattachment, how to register unattached patients, and how to best collect and interpret data related to unattached patients, one cannot help but wonder if we should have spent some time dealing with the question of *why* we are deploying much-needed resources chasing solutions to questions that will have little or no benefit in getting us out of the crisis we are in.

Unattached patients do not benefit from knowing how staggering their numbers are. Hospitals and social media are quite able to provide the public with information on primary care providers looking to increase their panels. Studying data will not increase the resource base required to achieve full attachment.

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In pursuit of #equanimity. Many #physicians I admire possess calmness, levelheadedness, and composure in difficult situations—a state of equanimity if you will—that I wish to emulate.

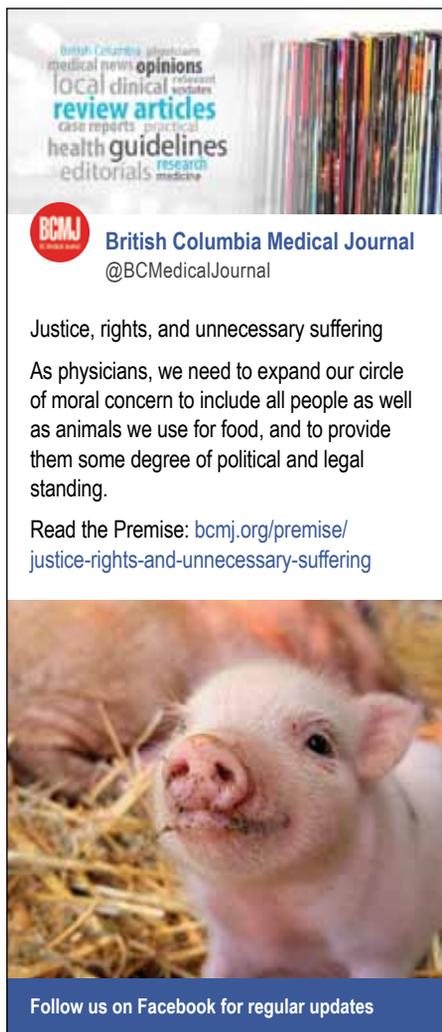
Read the President's Comment: bcmj.org/presidents-comment/pursuit-equanimity

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Could it be that this all has more to do with politics than solving the current crisis? It is concerning that primary care providers who want to access the new longitudinal care option for remuneration must agree to submit their complete panel data to the ministry and register with the provincial attachment list. We have been reassured so many times by the ministry that we will not be required to take on additional patients that one cannot help but conclude this is a case of “methinks the maiden doth protest too much.”

We need to be careful that we are not being duped into sharpening the blade of the guillotine that is soon to sever us from the long-serving autonomy of practice that we fought so hard to preserve over time.

—Bruce Nicolson, MD
100 Mile House



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Justice, rights, and unnecessary suffering

As physicians, we need to expand our circle of moral concern to include all people as well as animals we use for food, and to provide them some degree of political and legal standing.

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Re: Early-onset colorectal cancer

I want to express my gratitude to Dr Gray for his article addressing early-onset colorectal cancer [*BCMj* 2023;65:207-210]. While I value the article for its concise summary of this critical topic, I have several concerns, especially as a family physician and a patient personally impacted by early-onset colorectal cancer.

At the age of 36, I was diagnosed with stage IV colorectal cancer, despite being previously healthy and lacking any family history or known risk factors. My journey to diagnosis was fraught with delays and misdiagnoses. Initially, a specialist misdiagnosed my condition as hemorrhoids during an appointment I had waited 4 months for, providing me with a false sense of reassurance that only extended the time until my proper diagnosis. It wasn't until my rectal bleeding became severe that I presented to hospital. Even then, because my hemoglobin levels were within the normal range, I was considered low risk and almost sent home. I had to insist on an urgent colonoscopy, which finally took place the following day. Prior to the procedure, the possibility of malignancy was not discussed or considered, as all listed differentials were benign etiologies.

This was my experience navigating the health care system as a patient, despite being a physician who is well attuned to my own health. Regrettably, my story is not unique; I have connected with others in their 30s diagnosed with advanced-stage early-onset colorectal cancer who faced similar difficulties in accessing care. A common theme among them is that they were told by their primary care providers and specialists that they were “too young to have cancer.” It appears that there is a significant lack of awareness among both primary care physicians and specialists regarding the increasing incidence of early-onset colorectal cancer, especially in cases where there is no family history or obvious risk factors, as was the case with me.

The article commences with the well-intentioned statement that “[t]he BC

Guideline for colorectal cancer screening encourages physicians to evaluate younger adults with symptoms or a family history of colorectal cancer by using colonoscopy.” However, based on my experience as a family physician with years of practice in primary care, gaining access to a gastroenterologist for colonoscopy assessment is extremely challenging. Many times, I have had referrals flagged as “urgent” go unacknowledged, triaged as low priority with an 8- to 12-month wait, or worse, rejected for unjust or unclear reasons. I believe that many of my family physician colleagues can relate to similar experiences.

A recent systematic review on the role of colonoscopy in younger patients presenting with anorectal bleeding found that approximately 10% had a neoplastic lesion detected.¹ This underscores the importance of timely access to colonoscopy assessment for younger patients with colorectal cancer symptoms. I strongly advocate for a more efficient referral and access system for colonoscopy, particularly when colorectal cancer is suspected based on symptoms. I believe that implementing a centralized referral system, akin to the BC Colon Screening Program, which offers consolidated access to endoscopists (including gastroenterologists and general surgeons), would significantly enhance the current system's capacity to provide timely access to patients with concerning colorectal cancer symptoms, including those in the early-onset age range.

Last, I would like to acknowledge the success of the BC Colon Screening Program in patients aged 50–74 years. It has notably reduced the administrative burden for primary care providers and improved colorectal cancer screening access for our patients in this age group. On the question of lowering the screening age, I respectfully disagree with Dr Gray and advocate for lowering the screening age to 45, a topic on which I defer to my colleague, Dr Petra Wildgoose, for further discussion and exploration.

—Marko Yurkovich, MD, CCFP
Vancouver

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Thank you for highlighting the important issue of early-onset colorectal cancer [*BCM J* 2023;65:207-210].

In the article, it is stated that “population screening strategies in British Columbia remain unchanged, but recognition of possible early-onset colorectal cancer requires the vigilance of health care providers.” Diagnosis cannot depend strictly on the vigilance of health care providers when 59% of the population does not have a family doctor or has difficult accessing one and there is a known lack of public awareness of colorectal cancer symptoms and a delay in presentation to the primary care provider.^{1,2} Vigilance of health care providers assumes that providers are educated on the signs and symptoms of early-onset colorectal cancer, the reasons for considering it in the differential, and the significance of obtaining an urgent colonoscopy. It is well known that patients are often misdiagnosed and feel dismissed by their primary care provider.² Public and provider education regarding early-onset colorectal cancer is paramount.

It is also stated that “[t]he BC Guideline for colorectal cancer screening encourages physicians to evaluate younger adults with symptoms or a family history of colorectal cancer by using colonoscopy.” Delays in obtaining a colonoscopy are associated with an increased risk of advanced-stage disease, and the Delphi Initiative for Early-Onset Colorectal Cancer international management guidelines recommend that colonoscopy be performed within 30 days of presentation with alarming symptoms.³ (Red flag symptoms precede 70% to 95% of early-onset colorectal cancer cases.⁴) The Canadian Association of Gastroenterology Wait Time Consensus Group recommends endoscopy within 2 months. However, an Island Health 2020 performance assessment showed that 34% of patients waited

longer for colonoscopy than their priority benchmark, and a St. Paul’s Hospital 2016 retrospective chart review showed that symptomatic patients waited a mean of 86 days to endoscopy.^{5,6} BC Colon Screening Program 2019 results showed a median wait time to colonoscopy of 134 days after an abnormal fecal immunochemical test, and 85 days for patients at higher-than-average risk (including those with a family history).⁷ Given that symptomatic patients and patients eligible for screening colonoscopy are not being seen within target ranges, it seems highly unlikely that younger patients will receive timely access to colonoscopy once their symptoms are deemed worrisome enough by their primary care provider to warrant it. This statement as it stands is not sufficient; potential solutions need to be considered.

Four reasons are outlined as justification for not immediately adopting an earlier screening strategy. It is imperative to acknowledge that further discussion around lowering the screening age needs to occur through addressing various research gaps, including a comprehensive cost-benefit analysis of adopting population-based screening for individuals aged 45–50 at average risk of colorectal cancer, and a more detailed understanding of risk factor profiles, which could inform precision screening for early-onset colorectal cancer. Screening programs detect colorectal cancer at earlier stages of disease in the over-50 population, and, given that early-onset colorectal cancer patients are more likely to present with advanced disease, an understanding is warranted of whether lowering the screening age would reduce the stage of disease at diagnosis and, therefore, not only the physical and mental ramifications for the individual but also the downstream economic costs to both society and the health care system.

—Petra Wildgoose, MD, CCFP, MPH
Toronto

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