Letters to the editor

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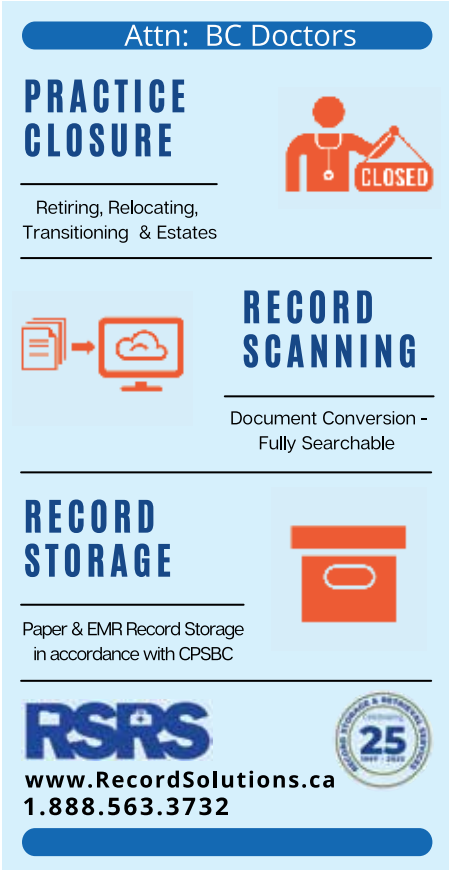
Provincial diagnostic standards for enteric pathogens

The questions raised by Dr Eugene Yeung in the September 2024 issue of the *BCMJ* regarding the oversight of diagnostic parasitology testing in British Columbia are important and strike to the core of having precision laboratory methods that should be expected in contemporary times.[1] This is even more relevant when, in an era of increasing complexity for medical care, the practising physician is likely to assume that state-of-the-art diagnostics have less room for imprecision.

If the dearth of diagnostic parasitology standards, as hypothesized by Dr Yeung, is true, it is imperative to more fully understand the full scope of practice and expectations. Dr Yeung's narrative and the provincial online guidelines for investigating infectious diarrhea are complete, with modifications and exceptions to the general recommendations for laboratory investigation.[2] Practically, however, and given the relatively narrow scope of such testing in the scheme of patient presentations generally, the practising generalist is unlikely to know of or have time to seek further details that may be relevant to the laboratory. The current standard laboratory requisition in British Columbia highlights dichotomous choices for a single collection for ova and parasite exam versus the same where two samples are collected for "high risk" settings.[3] One would most likely assume that the second diagnostic choice would make the very concerns raised by Dr Yeung as consideration for laboratory triage, including standard microscopic analyses. The addition of more detailed investigations according to the comments entered by a generalist physician on a laboratory requisition are sure to leave more room for error, since such comments are quite unlikely to occur, and understandably so.

Historically, guidelines that apply to laboratory practice have, not uncommonly, been driven by the desire to streamline Medical Services Plan payments for such work. That such guidelines should bind the given laboratory to limit its provision of diagnostic service is simply mistaken. Whether for diagnostic parasitology or other diagnostic microbiology, a one-size-fits-all approach may not be desirable. For example, diagnostic services in a tertiary care setting such as BC Children's Hospital or tertiary adult or regional hospitals are usually among the last resort when complex patients or uncommon diagnoses are to be investigated. A provincial laboratory's role in outbreak investigation mandates more flexible investigation. A referral travel clinic may have more variant inquiries. Each of these examples should at least allow flexibility for more conventional or detailed examinations as perceived by the diagnostic needs of that sample provider. The laboratory, therefore, must take leadership in understanding its client base and creating the flexibility to ensure that accurate and timely diagnostics are available.

The potential limitations of multiplex nucleic acid amplification testing are also well beyond diagnostic parasitology. One is essentially at the mercy of the testing spectrum for any given in-house or commercial compendium of assessments, including bacteria and viruses. For example, the BC Children's Hospital microbiology laboratory was sentinel in the early findings of a *Yersinia pseudotuberculosis* outbreak in 1998.[4] Communications thereafter with the provincial laboratory and public health soon led to the discovery of a large community outbreak linked to milk production.[5] This bacterial enteric pathogen would evidently not have been captured in the multiplex testing of today. In this regard, the maintenance of competency for standard testing methods by our tertiary diagnostic laboratories is also imperative.



Dr Yeung's year-long review provides considerable evidence for hypothesis testing. It is difficult to find published data from Canada about the predictive values of such multiplex testing when compared with historic standard laboratory diagnostics and where such assessment is made on a prospective basis. Whether there is a gain or loss in determining infection by using one or a combination of methods, an equally important aspect of such an investigation is the impact that missed or incremental laboratory diagnoses will otherwise have on treatment or patient care. Such relevant investigation is clearly in the capability of our medical microbiologists and their clinical clients.

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Anesthesia assistants in BC: Building the foundation first

Anesthesia assistants are highly trained medical professionals who work under the supervision of anesthesiologists. They are recognized as key contributors to the anesthesia care team.[1] The use of a team-based model of anesthesia care is common in other jurisdictions,[2] but in British Columbia, the model has been inconsistently applied and is underused. The Ministry of Health's Allied Health Strategic Plan, however, aims to optimize the roles and scopes of practice for allied health professionals to enhance patient care and improve health care system efficiency.

But anesthesia assistants are not regulated in BC. A regulatory framework would define their scope of practice; standards of practice; and requirements for education, certification, and ongoing professional development. The lack of a governance structure has resulted in variations in the recognition and use of anesthesia assistants. The profession is thus not working to its full scope across the province.

A recent pan-Canadian review and summary of anesthesia assistants' practices across the country showed that BC is an outlier with regard to governance.[1] The primary recommendation from the review

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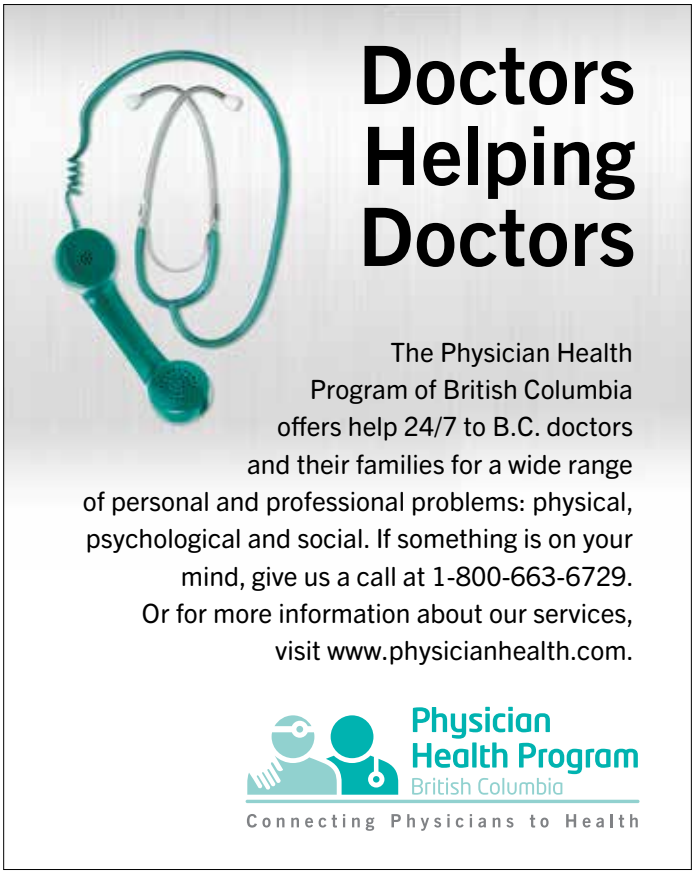

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was a call for recognition that widespread implementation of an anesthesia care team is needed to address growing surgical volumes and backlogs.[1] Additional authors have highlighted the opportunity across Canada to align with other team-based anesthesia practices that will increase access to surgical care for our patients.[2] We agree that the care team approach best serves our patients' needs. But, as a province, we need to first create the foundation on which we can build the team. We need to be proactive and take urgent steps to establish a regulatory framework for anesthesia assistants. We cannot continue with the status quo, which does not support enacting improvements to peri-operative patient care.

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