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.

Closure of the College Library: A proposal

The College of Physicians and Surgeons of BC announced the closure of the College Library (as of 15 March 2024) in an email sent on 1 March. I have reflected on the loss of this service since writing to the registrar of the College to express my concerns on 4 March.

I propose that urgent consideration be given to Doctors of BC taking over the operation of the College Library. I recall another valuable service kept running by Doctors of BC (then known as the BC Medical Association or BCMA). At that time, the Physician Health Program was in danger; the College decided it no longer wanted to share the operating costs of the program with the BCMA and withdrew from involvement. Thankfully, additional funding was obtained through negotiations between Doctors of BC and the provincial government, and this important program was maintained.

Please consider whether there might be a win-win solution here for the physicians of BC, and the patients we serve, to maintain continuity of the College Library.

The Library staff consists of four librarians and four library technicians. Since COVID-19, much of their work has been done virtually, so there would be little need in the way of space at the office at 1665 West Broadway in Vancouver. Proximity to the *BC Medical Journal* and Communications Department staff would be a bonus.

I am sure many of our members would like to see a continuation of the service and a valuable new membership benefit. The limited number of free pages of reference articles could be continued for Doctors of BC members, and a service charge introduced for others who access the Library.

Doctors of BC members have been invited to give input to the upcoming negotiations for the next Physician Master Agreement, and we could submit this proposal for consideration in the negotiations—something that the government might be asked to support and take some credit for.

There is an opportunity for Doctors of BC and the College to announce a process for the College Library to continue while still enabling the College's strategic planning that led to this decision.

Dr Bill Clifford, a pioneer in developing digital technology for physicians, has joined me in supporting this request. He incorporated a link to the College Library in the MOIS EMR.

The reason I ask for urgent action is to preserve the valuable experience of the current Library employees. Thank you very much for your consideration of this proposal.

—Ian A. Gillespie, MD, FRCPC, DIPABPN, DIPABLM
Victoria

Re: Diagnosing and treating adult attention-deficit/hyperactivity disorder

Dr Baerg Hall and Ms Cynthia Buckett provided an excellent and very detailed overview of the diagnosis and treatment of adult attention-deficit/hyperactivity disorder (ADHD) in the November *BCMJ* [2023;65:334-339]. The article provides step-by-step guidance for family physicians to address what seems like an increasing demand. I have worked collaboratively with family physicians at student health services at the University of Victoria and Simon Fraser University. We often discuss the challenges faced with diagnostic accuracy, especially considering other clinical factors. There is also concern about overdiagnosis when there is no opportunity to access collateral information from childhood. Another concern is the time involved in completing a detailed assessment.

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To address some of these issues, I put together a guide for anyone who might be considering getting assessed for ADHD and those who have a diagnosis and need information about both medication and nonmedication treatment. The guide includes step-by-step instructions and a checklist for patients to do much of the work gathering information to discuss with their physician. I hope this will save time in the assessment process and ensure physicians have more complete information to inform the diagnostic process.

The guide is available on the Pathways BC website under Mental Health—Adult > Information Handouts, Videos & Websites.

I have provided a detailed outline of an organizational approach based on widely available personal productivity tools. The tools are especially important for university students but may be relevant for anyone with a need to manage their busy lives. Artificial intelligence will be a game changer for people with ADHD, but having a basic understanding of personal productivity will very likely ensure successful application of this new technology.

I understand there may be other projects underway looking at ADHD assessment and treatment. I believe my guide would be a helpful adjunct to consider including. Please also send any suggestions or corrections to me at adhdguide@shaw.ca.

I would like to thank Dr Tracy Monk and staff at Pathways BC for their assistance with my project. Pathways BC continues to expand and provides an exceptional resource for physicians and patients.

—Michael Cooper, MD, FRCPC
Victoria

Slow medicine: Part of the solution to the primary care crisis

The primary care crisis stems from multiple causes. Some of them are being substantively addressed by the Longitudinal Family Physician Payment Model. Solutions to others (such as administrative burden and alternatives to family doctors having to be small business owners) are actively being sought and implemented. I'm interested in addressing some of the causes that aren't as widely acknowledged or discussed.

It is estimated that 30% of the tests, treatments, and procedures we order are unnecessary and 10% of them are harmful.[1] Current approaches designed to address this issue struggle to move the dial. The remedy will require a deeper look at the values and assumptions that drive what we do. Dr H. Gilbert Welch's book *Less Medicine, More Health: 7 Assumptions That Drive Too Much Medical Care* addresses some of them—more information is always better, action is better than inaction, and early diagnosis is always better.[2] Additional drivers of too much medicine include our society's fear of death, black-and-white ideas about health and disease, and discomfort with uncertainty. Additionally, the influence of private interests on guidelines and standards of care has not been adequately addressed.

In a crisis, we need to go back to the basics: What is good health care? What is the goal of the work we do? I've considered this for some time and have come to this conclusion: good health care enables people to live their best lives. Good health care shows up when you need it and does as much as is necessary to restore health and balance to allow you to continue to live your life. Critically, it seeks to not do harm.

There are many movements in medicine that aim to keep that goal central by raising the questions and offering approaches to help us discern the better path. Some of them are realistic medicine, value-based health care, minimally disruptive medicine, less is more medicine, sustainable health care, and slow medicine. I like the framework slow medicine provides, because it gets to the fundamental assumptions. Its name immediately calls out one assumption to be questioned: Is fast always better?

Most of us working in the Canadian health care system have a visceral sense of our current system's tempo. Fast, always; needs to be faster still. We could call it fast medicine. Often the quickest (and, importantly, the most lucrative) response to a patient or a result in front of you is to do something: write a prescription, order a test, make a referral, or ask the patient to book another appointment. Those may or may not be the correct actions. All of them create more demand on the system and require more physician hours. Fast medicine contributes to polypharmacy, fragmented care, overdiagnosis, overmedicalization, and the resultant inappropriate care. Not only that, every interaction with the health care system has an environmental cost: the transportation required for patients to attend multiple visits, the energy and resources required to produce medications and provide laboratory and medical imaging services, not to mention the waste.[3] Fast medicine decreases our joy in our work, and I believe it is a significant factor in the lack of family physicians willing to start or remain in a longitudinal practice.

Slow medicine originated in Italy (after the slow food movement) and is based on medicine that is measured, respectful, and equitable. Slow medicine acknowledges the powerful intervention of time and of healthy skepticism and vows to remember our potential to cause harm. The principles of slow medicine include using evidence-based medicine to discern between effective and ineffective care (demanding the benefit be

more than marginal), without commercial interests at the table shaping those determinations; the concept of health as inclusive of the psychological, spiritual, social, and environmental realms alongside the biological; and health and well-being as complex and more than the sum of our bodily functions or the age we reach. The default shouldn't be testing and treating but rather deliberate, careful, and measured actions. Slow medicine upholds a stance of curiosity and humility, resists the falsity of certainty, and requires an openness to doubt.

Although there is no formal slow medicine movement in Canada (yet), I've been experimenting with implementing the approach in my own practice. I've scheduled more time with patients, as well as time to think about my patients and review their charts. I make more time to call the consultants involved for advice, which often leads to fewer referrals and more useful investigations. I also share my expertise as a family physician, which includes the patient's broader medical context and the whole person–centred lens (their values and life context to the best of my understanding). As a generalist, I endeavor to add value to the conversation by bringing a respectful skepticism of possible interventions. I aim to order fewer unnecessary tests and have sought to be more deliberate in deciding whether a follow-up appointment will contribute to a patient's well-being. I listen more deeply to my patients, making space for their wisdom on how best to approach their health and acknowledging that my priorities are often not theirs. I've also spent more time finding and sharing information about the actual magnitude of benefit a medication or intervention might provide, and I find it is routinely less than both the patient and I believed (over-attribution of benefit). During this process, I am starting to see Western medicine more clearly—the good and the bad. I see the laudable achievements. We have many tools we can use to decrease suffering and improve our patients' lives; I want to use those well. I also see that there is much we do that is unlikely to improve our patients' well-being or that harms them, the health care system, and the environment.

Let's not waste the opportunity our health care crisis is offering to look closely and critically at what we do and why we do it.

—Jill Norris, MD, CCFP
Victoria

References

1. Canadian Institute for Health Information. Unnecessary care in Canada. 2017. Accessed 27 March 2024. www.cihi.ca/sites/default/files/document/choosing-wisely-baseline-report-en-web.pdf.
2. Welch HG. Less medicine, more health: 7 assumptions that drive too much medical care. Boston, MA: Beacon Press; 2015.
3. Cascades. Sustainable primary care toolkit. Accessed 27 March 2024. https://cascadescanada.ca/resources/sustainable-primary-care-toolkit.