July/August 2024: 66:6
Pages 185–224

IN THIS ISSUE

Clinical Images: Ultrasonographic findings and treatment in heterotopic cesarean scar pregnancy

Original Research: Eliminating the routine use of examination table paper in outpatient oncology clinics

Premise:
- **Real-Time Virtual Support quick-reply pathways**
- **What to consider when seeing patients with work-related health concerns**

BCCDC: Respiratory virus surveillance after the height of the COVID-19 pandemic

COHP: Is food insecurity the issue, or is it discrimination?

Impact of the family physician shortage on BC specialists' health and well-being

BCMJ
BC Medical Journal
July/August 2024
Volume 66 | No. 6
Pages 185–224

A study at BC Cancer outpatient clinics demonstrates that eliminating exam table paper can reduce both costs and carbon dioxide emissions. Article begins on page 204.

Mission: The *BCMJ* is a general medical journal that shares knowledge while building connections among BC physicians.

Vision: The *BCMJ* is an independent and inclusive forum to communicate ideas, inspiring excellent health care in British Columbia.

Values
Quality: Publishing content that is useful, current, and reliable.
Connections: Sharing diversity of thought and experiences from across the province and promoting communication between BC doctors.
Impact: Striving for healthier patients and communities by amplifying physicians' voices, opinions, research, and news.

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188 Editorials
- Celebrating Pride!
  Caitlin Dunne, MD
- Pain in the butt
  Sepehr Khorasani, MD

191 Letters
- Closure of the CPSBC medical library
  Teresa Marie Kope, MD
  Barry Koehler, MD
  Tracy Morton, MD
  Margo Clarke, MD
- Moving beyond the hidden curriculum: Am I ableist?
  Judy So, MD, Cynthia Vallance, BA, Esther Lee, MD
- Lack of universal oral thiamine coverage a missed opportunity for alcohol harm reduction in BC
  Eastside Illicit Drinkers Group for Education, Aaron Bailey, MSc, George Sedore
- Drs Christensen and Reeve
  Phyllis Reeve

195 President's Comment
The pursuit of equity
Ahmer A. Karimuddin, MD

196 Premise
Real-Time Virtual Support quick-reply pathways
B.R. Ohata, MD, R. Connop Price, A. Yee, MD, I. Lupu, MD, N. Kitson, MD, D. Johnston, MD, J. Pawlovich, MD

ON THE COVER
A qualitative study of specialists in Victoria demonstrates that the family physician shortage has numerous negative consequence on specialits and the care they are able to provide to patients. Article begins on page 210.

Editor-in-chief
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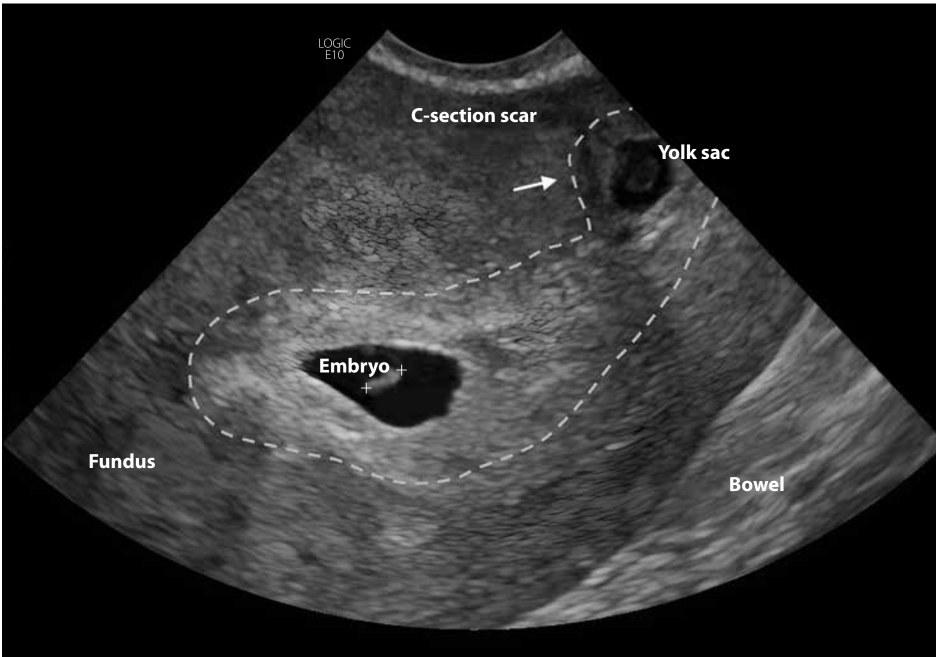

In the first entry into the BCMJ's new Clinical Images department, we see a rare case of heterotopic cesarean scar pregnancy. See page 202.

198 Premise
What to consider when seeing patients with work-related health concerns, **Nikhil Rajaram, MD, Sylvie Hudon, MD, Marina Afanasyeva, MD**

202 CLINICAL IMAGES
Ultrasonographic findings and treatment in heterotopic cesarean scar pregnancy
Samantha R. Saravana-Bawan, MD, Karen Letourneau, CRGS

204 CLINICAL: ORIGINAL RESEARCH
Eliminating the routine use of examination table paper in outpatient oncology clinics, **Caroline Mariano, MD, Hannah Wells, BSc, Maura Brown, MD, Krista Clement, BSc, Rae Wooffindin, BSN, Kevin Hare, BSN, Shilo Lefresne, MD, Jagbir Kaur, BSN, Michael Darud, BSc, Vincent Chui, BSc, Jane Sun, BSc**

210 CLINICAL: ORIGINAL RESEARCH
Impact of the family physician shortage on BC specialists' health and well-being, **Anna Mason, MD, Kristin Atwood, PhD, Frieda Hodgins**

215 COHP
Is food insecurity the issue, or is it discrimination?
Selena Lawrie, CCFP, Jennifer M. Phillips, CCFP

216 BCCDC
Respiratory virus surveillance after the height of the COVID-19 pandemic, **Megan Edwards, PhD, Yayuk Joffres, MPH, Agatha Jassem, PhD, Natalie Prystajecky, PhD, Jimmy Lopez, MSc, Reza Hosseini, MD, Carl Zou, MDS, Hana Hua, MSc, Aamir Bharmal, MD, Anya Smith, PhD, Diana Bark, MD, Caren Rose, PhD**

217 WorkSafeBC
The WorkSafeBC Critical Incident Response Program: A resource for you and your patients
Amber Sawkins, MSW

219 Obituaries
- Dr Frances Carolyn McGrath
- Dr Abdel Aziz Ahmed (Aziz) Nazif
- Dr Michael G. Bendall
- Correction: Recently deceased physicians

221 Classifieds

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Celebrating Pride!

Canada Pride 2024 in Vancouver takes place from 26 July to 4 August. Pride marks a time of celebration, advocacy, and reflection for the LGBTQIA2S+ community. Vancouver's Pride parade is on 4 August 2024.

My colleagues and I at the Pacific Centre for Reproductive Medicine have marched in every Pride parade since 2016. I have also had my children alongside me in the parade since they were babies—it's a great event for kids, as Pacific Street turns into a collective rainbow bash of positive vibes, water guns, and music. One year, my son had the honor of being interviewed by the drag queens hosting the television coverage. My son was bursting with pride when they announced to the crowd that his mom was their fertility doctor! After that encounter, my kids assumed that my office was basically an all-day dance party.

Beyond the parties, Pride is more than symbolism and pageantry. As physicians, we have a unique responsibility to foster inclusivity by providing equitable health care for all individuals, regardless of sexual orientation or gender identity. While British Columbia boasts progressive values, it's essential to acknowledge the persistent health disparities faced by those who identify as LGBTQIA2S+. Research tells us that members of this community experience higher rates of certain mental and physical health issues compared with their cisgender, heterosexual counterparts.[1] Discrimination, stigma, and lack of access to affirming health care services are some of the contributors to this disparity.

Pride marks a time of celebration, advocacy, and reflection for the LGBTQIA2S+ community.

Pride can be an opportunity for health care providers to reflect on our role in these disparities. LGBTQIA2S+ individuals face an ongoing struggle for rights and equality. This is an opportunity to re-examine and re-affirm our commitment to providing compassionate and culturally competent care to all patients.

There are many ways to improve how we deliver inclusive health care. Each of us knows our own unique patient populations and strives to evolve to meet their needs. One aspect of affirming medical care might include continuing education, such as keeping up with the latest guidelines or educating team members on inclusive language. We can display visible symbols of support, such as Pride flags, so that patients know our facilities are safe spaces where they can express their identities without fear of judgment or discrimination. Egale Canada (formerly Equality for Gays And Lesbians Everywhere; https://egale.ca) and Trans Care BC (www.transcarebc.ca) are two resources I've found helpful, but there are many others. Please comment online or email the *BCMJ* if you have resources or advice to share.

In Vancouver and across BC, we are fortunate to have a vibrant and active LGBTQIA2S+ community that provides support and resources to its members. Health care providers can find ways to stay actively engaged, seeking input and feedback to assess how our services are meeting the community's needs. Pride season is a powerful reminder that together we can build an inclusive, compassionate, and equitable health care system. Happy Pride! ■

—Caitlin Dunne, MD, FRCSC

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Vancouver Pride parade, 2023.

Pain in the butt

Anorectal complaints can be a "pain in the butt" for both patients and physicians. Many patients believe hemorrhoids are to blame for problems "down there," such as bleeding, pain, irritation, itchiness, swelling, or protrusion. This perception, along with feeling embarrassed when discussing anorectal complaints and anxious about the eventual examination, can be a barrier to seeking help. At times, patients can be so convinced of a self-diagnosis of hemorrhoids that they relabel the term *rectal bleeding* as "hemorrhoids acting up." When I ask "Have you had any rectal bleeding?" a common response is "Oh, no . . . no, doc . . . just hemorrhoids, you know . . . I've had them all my life."

"The very first step towards success in any occupation is to become interested in it."[1]
The problem is that many anorectal pathologies can have overlapping symptoms. Therefore, one should always keep an open mind when taking history and an open eye when performing physical examination, as part of a stepwise approach in managing patients with anorectal complaints. "I would start by taking a full history and performing a complete physical examination." I am sure most of us used this blurb when answering questions for the Royal College of Physicians and Surgeons of Canada oral exam; it gave us the sought-after checkmark on the scoring sheet and should do the same in real life!

"Listen to your patient, he is telling you the diagnosis."[1]
It has been said that surgeons are not always the most thorough history takers. When it comes to assessing patients with anorectal symptoms, asking the right questions and looking for patterns are fundamental. Most of the time, I have a very good idea of what the diagnosis will be by the end of history taking. For example, sharp, razor-like pain, starting with bowel movements and lasting up to a couple hours after, with associated blood on toilet paper or coating the stool, all preceded by recent episodes of constipation, has a diagnosis of anal fissure written all over it. Experiencing discomfort (not sharp pain), with perianal "swelling" after bowel movements, bright-red blood on toilet paper or dripping into the toilet bowl, mucus discharge, and having to "push things back" at the end point to prolapsing hemorrhoids or possibly rectal prolapse. And last, a nonhealing wound with persistent discharge after incision and drainage of a perianal abscess usually suggests the diagnosis of anal fistula.

Just as patients blame everything on hemorrhoids, I treat everything with fibre (well, not exactly, but at least as a starting point in many cases).

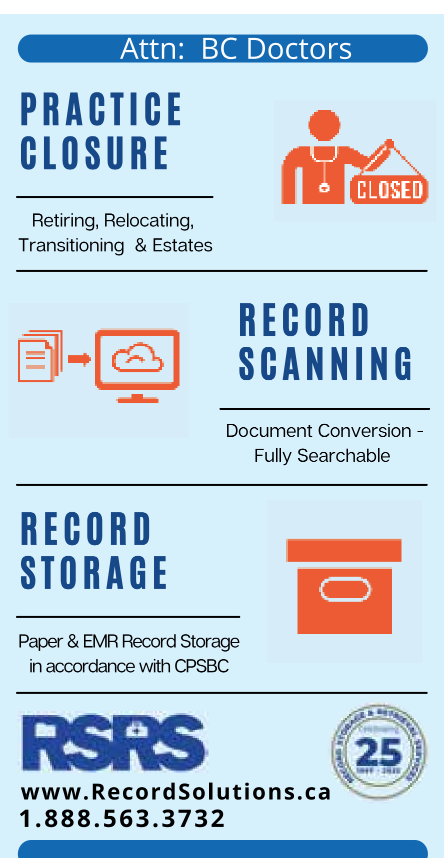
As when treating any condition in medicine, it is helpful to have a list of the most common causes for various anorectal complaints. For example, when seeing a patient with anorectal pain, I usually have the following three at the top of my differential diagnosis: anal fissure, perianal abscess, and thrombosed external hemorrhoids. Of course, a fungating anorectal cancer or Levator syndrome can also cause anorectal pain, but they are not as common. Nevertheless, the next step—a physical examination—is key in confirming the diagnosis and ruling out other ominous pathology.

"The whole art of medicine is in observation . . . but to educate the eye to see . . . and the finger to feel takes time."[1]
As you reach the end of history taking, you are itching to move on to examine the patient so you can confirm what you have postulated as the most likely diagnosis. This is your moment to shine. The feeling is akin to the moment you are being "pimped" as a surgical resident in the operating room by the attending surgeon and you answer every question correctly. A gratifying sense of accomplishment confirming you know your stuff and have gained the trust of your attending; yes, believe it or not, there can be moments of gratification when managing patients with pain in the butt and beyond.

"One finger in the throat and one in the rectum makes a good diagnostician."[1]
Ignore the throat part (unless the patient has dysphagia, and if so, make sure to change your gloves or at least examine the throat first!). In addition to visual inspection, digital rectal examination (DRE) must be performed on any patient with anorectal complaints; this is where telehealth has no place. And don't be shy; you do not want to miss a distal anorectal mass just because you didn't want to cause the patient more discomfort. This is an unpleasant exam, and the patient is going to be uncomfortable regardless, so you might as well make the most of it. A missed diagnosis of anorectal cancer, waiting on the specialist triage list for months because of a negative DRE, is what we really hope to avoid. One exception where DRE may be deferred is when the history is consistent with and you see an obvious anal fissure on exam. Regardless, bring the patient back for re-examination, including DRE, once symptoms have improved after a short trial of treatment.

"There is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language."[1]
Be as descriptive as you can when

documenting anorectal symptoms and pathology. You do not have to commit to a diagnosis, but, if using diagnostic terminology, make sure it represents your impressions correctly. For example, fecal incontinence is a common complaint, especially in our aging population. It is important to clarify the nature, frequency, circumstances, and impact on quality of life. Often what patients or physicians perceive as fecal incontinence is in fact new onset urgency, staining secondary to poor hygiene as a result of hemorrhoids or skin tags, or mucus discharge related to anorectal tissue prolapse. Speaking of anorectal prolapse, the term *rectal prolapse* in both general and colorectal surgery usually refers to full thickness rectal prolapse. Once you see a full thickness prolapse (in a patient or on Google Images), you will appreciate the difference between hemorrhoidal and full thickness rectal prolapse. The treatments for these two entities are very different, with the latter almost always surgical and the former mostly non-operative. Last, when localizing anal pathology, use terminology such as posterior/anterior and left/right (or variations of these) in relation to the side of the patient. This way you don't have to worry about mixing up the clockface, as this can change depending on the position the patient is examined in (as a commonly accepted rule, the clockface should refer to a patient in lithotomy, with 12 o'clock anterior and 3 o'clock left of the patient).



"The good physician treats the disease; the great physician treats the patient who has the disease."[1]

After diagnosis comes the grand finale, putting it all together. Symptoms, signs, and expectations should all be considered to prescribe an effective, patient-tailored treatment regimen. Not all hemorrhoids or skin tags need to be treated or removed if they are not the root cause of the problem or if the risks outweigh the benefits. Additionally, if you plan to refer the patient to a surgeon, initiate treatment regardless. Considering the current health care constraints and wait times, it may be months until they see the surgeon. Having some knowledge of first-line treatment options and encouraging patients to follow the recommended treatment in the meantime will help the surgeon determine whether more invasive or advanced treatment is necessary at the time of surgical consultation.

Symptoms, signs, and expectations should all be considered to prescribe an effective, patient-tailored treatment regimen.

"One of the first duties of the physician is to educate the masses not to take medicine."[1]

Almost everyone with the presumed diagnosis of hemorrhoidal disease uses or is told to use hemorrhoid creams. These products usually contain a combination of various ingredients, including steroids. Although they can sometimes improve symptoms (probably more by placebo effect than anything else), there is no robust evidence for their use. I tend to stay away from these products, especially for prolonged use, as they can cause skin irritation and sensitization, which can make things worse. The key is to address the underlying triggers that led to the disease.

Last, keep in mind that many anorectal symptoms improve with simple dietary and lifestyle modifications. Just as patients blame everything on hemorrhoids, I treat everything with fibre (well, not exactly, but at least as a starting point in many cases). Whether complaints are secondary to symptomatic hemorrhoids, fissure, irregular bowel habits, defecatory dysfunction, or fecal incontinence, ensuring adequate fibre and fluid intake (at least 25–35 g of fibre and 6–8 glasses of water a day) can often improve, if not resolve, symptoms.

"Medicine is a science of uncertainty and an art of probability."[1]

Finally, one should have a low threshold to refer patients with rectal bleeding for endoscopic evaluation. With the increase in incidence of early onset colorectal cancer, we should always keep more ominous causes such as colorectal neoplasms in mind when managing such patients. This, of course, should be put in the context of clinical presentation and patient risk factors. ■

—Sepehr Khorasani, MD, MSc, FRCSC

Reference

1. Life in the fastlane. Oslerisms. Accessed 12 June 2024. https://litfl.com/eponymictionary/oslerisms.

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 CPSBC medical library

I am grateful to Dr Caitlin Dunne for her editorial[1] and to Dr Ian Gillespie for his letter[2] in the May *BCMJ* regarding the recent closure of the College of Physicians and Surgeons of BC (CPSBC) medical library. As a psychiatrist in private practice, I have relied on the CPSBC library for several decades, as I have not had access to either a hospital or a health authority library. The closure of the library, with no warning to registrants, caused me to feel not only shock but also a sense of significant loss. I echo Dr Dunne's insightful comment: "In losing the CPSBC library, I believe we've lost a valuable member of our health care team."

On the other hand, the CPSBC's rationale for the closure ("significant decrease in library use over the years") did not make sense to me. In medicine, we continue to offer treatments we deem important, such as immunizations, even when uptake in some areas may be decreasing. The CPSBC library provided a valuable service. In particular, the assistance from the librarians and library technicians was exceptional. The fact that usage had declined does not justify the closure.

I relied on the library to provide literature searches for complex and challenging clinical situations. I took advantage of two literature search trainings provided by the library, and even still—not surprisingly—the librarians were much more skilled in finding relevant information in a timely manner. I also regularly read the monthly *Cites & Bytes* newsletter, which helped me stay informed about areas outside my specialty. At a time when there is a physician shortage, it does not make sense to add to the workload of physicians by terminating library services.

The CPSBC's 2021–2024 strategic plan includes, under the "engagement" theme, "to provide ongoing education and access to resources to support [registrants] in practice."[3] Closing the library is a short-sighted decision and runs counter to this goal.

I had the pleasure and privilege of serving on the CPSBC Library Committee about 10 years ago. This experience only strengthened my respect and admiration for the library staff, under the wonderful leadership of Dr Karen MacDonell. Another specialist on the committee commented that he would not have been able to fulfil his professional role without the support of the library. I feel the same.

Moving forward, I fully support Dr Gillespie's suggestion that Doctors of BC take over the operation of the library.[2] This is an excellent suggestion that I hope is supported by many of our medical colleagues. The library is a wonderful resource that needs to be protected and nurtured, not only for our benefit but also for the benefit of our patients.

—Teresa Marie Kope, MD, FRCPC
Vancouver

I agree with Dr Dunne in deploring the closing of the College Library.[1] It has been an excellent and efficient service for the physicians of the province.

It is not surprising that library use has declined over the years, given the easy access to information via the Internet. However, such information is often biased, and access to original articles is limited. For those of us who wish to research our information, the Internet is generally inadequate. For the College to close the Library based on declining use suggests that the College feels the ability of its members to find adequate and accurate information is not important. This reflects poorly on the College board.

While I do not disagree with Dr Ian Gillespie's proposal that Doctors of BC take over the library,[2] I have another suggestion. The University of British Columbia has an excellent library, with easy online access to full-text articles. Why not come to an arrangement with UBC, so that Doctors of BC members are able to access the UBC Library? This would likely be less costly than running our own library and would give the UBC Library more funds to operate with.

Whatever is done, 'twere best done quickly.

—Barry Koehler, MD, FRCPC
Vancouver

I read with sadness that the venerable College Library closed in March 2024.[1,2] It's a decision I understand, considering how reliable medical information is acquired by practitioners in 2024. When I first entered practice as a rural generalist in 1999, the latest medical information was acquired through subscriptions to print publications like the *New England Journal of Medicine*, *Canadian Family Physician*, and *JAMA*. This was supplemented by the *Cites & Bytes* monthly mailing from the College Library to inform me about newly published studies in a range of areas of medicine. Each month, I faxed in my order form, checking lots of

boxes, and marveled at how I received an envelope of the study reprints I wanted 10 days later. My, how times have changed.

With the Internet, practitioners now have access to information the moment it is published, without the need for libraries to curate and intermediate between source and consumer. We can access journal websites directly, without the need for a library to house the print journals. UpToDate, ClinicalKey, StatPearls, and other sites provide answers to clinical questions, essentially at the point of care. Before, I would have to rely on a librarian to answer a question like "What are the latest treatments for primary biliary cirrhosis?" Now I type that into a search engine or data aggregator of my choice and get an answer in moments. Or I listen to medical podcasts hosted by professional societies, journals, and scientists who package new information and guidelines into audio formats that educate while entertaining. Or I follow #FOAMed leaders' websites to hear their takes on what's happening in medicine. Like legacy media, the Internet and its myriad medical websites have made a library a place I don't think to consult to help me answer clinical questions and stay current. With that value proposition largely lost, I can understand why the College made the hard decision to close the Library.

So, what now? Is there something else the College Library could do or be? The answer is yes, but through repurposing to better serve registrants in areas the Internet cannot. Besides working as a clinician, I've conducted research and marveled at how ill-prepared I've been. I would have loved to have had a knowledgeable librarian guide me through research methodologies, statistical analyses I could have done, and literature reviews to help me know what's been published before. Or how about a librarian who can help me develop a learning plan on how to develop a skill, such as point-of-care ultrasound, or how to prescribe opiate agonist therapy? Or maybe a librarian becomes the data scientist who helps with guideline development or advises a health authority on how to implement a new clinical service with lessons learned from other jurisdictions. I've appreciated the College Library staff for many years, and I'm hopeful they can apply their considerable skills to new roles and purposes.

—Tracy Morton, MD, CCFP
Haida Gwaii

Thank you, Dr Dunne, for your editorial on the closure of the College of Physicians and Surgeons of BC (CPSBC) medical library.[1] Additionally, I am most grateful to Dr Gillespie for his proposal that Doctors of BC take over the library.[2] This is an excellent idea and provides a hopeful way forward.

Dr Dunne was curious to hear from *BCMJ* readers regarding what the medical library, or lack thereof, means to us.

I was shocked and saddened to hear of the closure—which was announced without warning. I believe it is a step backward and, hence, most unfortunate. The closure will limit articles read and may siphon thought in specified directions rather than enabling a broader perspective. Costs of publication are significant, so the vast majority of articles are not free to access. The additional fee for an article to be freely available on PubMed or other servers requires a premium dollar, so it often requires financial backing. This tiered system can skew what is read. It can delay the introduction of novel findings or concepts. The CPSBC library system enabled all articles to be read by simply contacting the librarian, who would send any desired paper. This is a major asset to getting a clearer picture and speeding up progress.

I realize there are excellent new sources of information that guide clinicians' decision-making processes and can be quickly read and applied. In the clinical practice setting, this is what is needed. There is very little time for anything else at that critical juncture. However, for unusual and rare disorders and research to advance disease management, access to as many articles as possible is most helpful, and that is where I see a void has been created that will leave BC physicians at yet another disadvantage.

The CPSBC library staff have always provided exemplary service. Hence, Dr Gillespie has highlighted the need for urgent action to preserve the valuable experience of the current library employees.[2] Should Doctors of BC act on Dr Gillespie's proposal, a vote on maintaining library services may ensue. Maintaining library services is an investment in the future, enabling physician-scientists to not only remain current but also become leaders in their field.

—Margo Clarke, MD
Pender Island

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1. Dunne C. The CPSBC closed our medical library. BCMJ 2024;66:104-105.
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3. College of Physicians and Surgeons of BC. Strategic plan 2021–2024. Accessed 15 May 2024. www.cpsbc.ca/about/corporate/strategic-plan.

Moving beyond the hidden curriculum: Am I ableist?

The e-book *Am I Ableist? Disability Awareness in Healthcare*[1] was written by medical students from Dalhousie University, in collaboration with disability advocates, researchers, and people with disabilities. Prompted by the lack of resources addressing ableism within medical education, it was created with the goal of challenging medical students to be more intentional in how they view and address disability throughout their training.

The e-book begins with a historical overview of how physicians have used disability to institutionalize and further disadvantage ethnic minorities and people of lower socioeconomic status. This highlights physicians' power to influence societal views, which can translate to ableist policies. Even today, society often looks to physicians to understand and label disabilities; physicians are gatekeepers to resources. All medical students will have opportunities to either advocate for their disabled patients or continue to propel the ableist voice in health care and society. Thus, it is essential that future physicians are exposed to and understand patients' disability experience, in the same way they receive cultural

competency training. As it stands, medical students rely heavily on the hidden curriculum and observation of preceptors for disability-related training.[2] *Am I Ableist* provides a well-researched, unbiased view into the disability perspective. It offers concrete examples of ableist language commonly used in clinical settings and provides alternative phrases that are both thoughtful and approved by those with disabilities.

It wasn't until I [author J.S.] read this book as a fourth-year medical student that I reflected on physicians' role in perpetuating ableism. I believe that learning more about the disability perspective would have allowed me to use language more intentionally and with confidence.

Author C.V.: "My daughter has cerebral palsy, and I encourage both physicians-in-training and practising physicians to read this book. It makes a huge difference to parents when physicians recognize the weight people with disabilities and their loved ones carry. We wear so many hats and are expected to keep everything together. Having a physician take the time to learn what is important to our family conveys that they also want the best for our child—*this* is what makes the journey manageable."

In the same way physicians have patient interactions they remember for the rest of their careers, patients and caregivers hold on to their experiences with physicians for the rest of their lives. It is essential for medical students and health professionals to provide trauma-informed care to all patients and to recognize within themselves the language that can perpetuate ableism.

Here are three reasons you should read this book:

- It provides clear examples of ableist language commonly used by physicians, with alternative suggestions.
- It provokes self-reflection about unconscious biases we may have and explains the impact this could have on our patients with disabilities.
- It offers opposing views on the disability perspective to provide an unbiased perspective on the subject.

Download a free copy at https://bit.ly/amiableist.

—Judy So, MD
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Note: When this letter was first drafted, Dr So was a fourth-year medical student; it was written as part of a UBC FLEX project.

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Lack of universal oral thiamine coverage a missed opportunity for alcohol harm reduction in BC

Thiamine supplementation is a recommended best practice in alcohol withdrawal management, outpatient care, and harm reduction for people who are diagnosed with severe alcohol use disorder, a population that includes many managed alcohol program (MAP) service users.[1] In spite of thiamine's efficacy as treatment prophylaxis for many acute and chronic alcohol-related harms, including malnourishment, alcohol-related liver disease, Wernicke encephalopathy, and Korsakoff syndrome, gaps in access to affordable vitamin B1 are stark for structurally marginalized illicit drinkers.[2-4] The Eastside Illicit Drinkers Group for Education, a collective of current MAP clients, former illicit drinkers, and allied community organizers working to reduce alcohol-related harm in Vancouver's Downtown Eastside, urges policy change to improve access to oral thiamine throughout BC. The inclusion of oral thiamine on the BC PharmaCare Plan C formulary is a logical and attainable first step toward this goal.

In BC, intramuscular thiamine HCl injections (DIN 02193221) have been covered by numerous PharmaCare plans since February 2018. In contrast, prophylactic oral thiamine HCl 100 mg (DIN 00816078), which is anecdotally preferred by MAP service users in Vancouver and recommended by the BC Centre on Substance Use 2023 Canadian clinical guideline for high-risk drinking and alcohol use disorder, is exclusively covered by PharmaCare Plan W.[1,5] Without broader coverage for over-the-counter thiamine supplements, a significant segment of the high-risk drinking population is unable to regularly access oral thiamine from health care providers or MAP services, choosing instead to pay out of pocket on low incomes.

While holistic Plan W coverage will always remain a crucial part of care for eligible MAP clients who are Indigenous, the potential for oral thiamine to reduce health harms and associated costs for drinkers not presently covered by First Nations Health Benefits will remain unrealized in the absence of universal coverage under BC PharmaCare.

The Eastside Illicit Drinkers Group for Education routinely advocates for the benefits of thiamine supplementation to our membership. Steering committee members regularly review the scholarly literature on vitamin B1 supplementation for alcohol use disorder clients, create resources to support our drinkers,[6] lead educational meetings with peers, and share our own experiences of benefiting from thiamine supplementation. Our sweatshirt sleeves proudly read "Take your thiamine." While we will continue to advocate for (and, in many cases, provide) oral thiamine to our MAP and non-MAP client membership as needed and at their discretion, we feel that the broader inclusion of oral thiamine on BC's provincial formulary is necessary to realize the clinical benefits of this work at a larger scale.

—Eastside Illicit Drinkers Group for Education

—Aaron Bailey, MSc
Program Coordinator, Vancouver Area Network of Drug Users

—George Sedore
Steering Committee Member and Community Organizer, Eastside Illicit Drinkers Group for Education

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Drs Christensen and Reeve

Your list of recently deceased physicians in the May 2024 issue [*BCMJ* 2024;66:135-136] includes Dr Ralph Marenus Christensen. I did not know Dr Christensen personally, but he was part of an event that looms large in my memory. According to the obituary in the *Vancouver Sun*, "[a] highlight of his career was leading the surgical team to complete the first kidney transplant in Western Canada in 1968."

My late husband, Dr C.E. (Ted) Reeve, was on that same team, and it was indeed a highlight for all concerned. The people of Vernon were especially proud because Ralph was born and raised there, and Ted was the son of the rector of All Saints Anglican Church in Vernon. A front-page headline in the *Vernon News*, 31 October 1968, read: "First kidney transplant. Two aid in operation." There were at least a dozen doctors on the team, but these two were the local heroes.

—Phyllis Reeve
Gabriola Island

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The pursuit of equity

When Doctors of BC was developing our most recent strategic plan, extensive conversations took place around how to address equity for our members and the best way to incorporate equity as a key principle. In this context, equity is our commitment to provide every member with the support needed to access the same participation opportunities in Doctors of BC without barriers and to embed an equity lens in all aspects of our work. As the organization develops strategies to live this commitment, it is important for us to remind ourselves why this journey is important for our members as human beings and for our profession as a truly human calling.

When it comes to equity in health care, research shows that women are more likely to report burnout and decreased job satisfaction, and minority physicians are more likely to face discrimination, have decreased job satisfaction, and have more conflicts with senior leadership. But when those of us who work in the health care system value equity, there are benefits for everyone. Valuing equity and positioning it as a foundational principle in our system lead to improved individual physician well-being, patient satisfaction, and clinical outcomes. Ample data show that more diverse health care systems provide more accurate diagnoses and create better therapeutic alliances with patients, enhancing patient compliance and happiness with care plans.

How do we then implement and embody this foundational principle of equity in our health care system? We begin at the individual level by fostering respectful dialogue and communication between physicians in all scenarios—in person, email, telephone, messages, and so on. Those of us who work in team or departmental settings should be part of conversations about why equity is important, and not just for those who have historically been marginalized. If we want our health care system to deliver high-quality results, we must take ownership of creating relationships and structures that embody the highest quality of human interaction, regardless of our intersectionality.

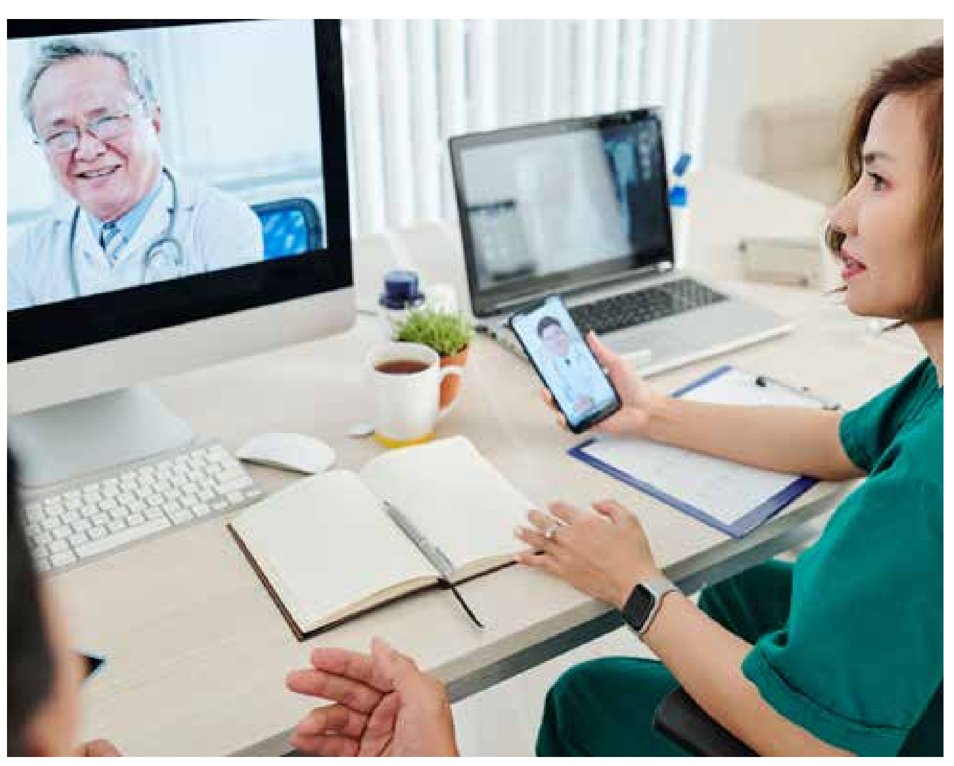
Equity is our commitment to provide every member with the support needed to access the same participation opportunities in Doctors of BC without barriers and to embed an equity lens in all aspects of our work.

Beyond including equity as one of the pillars of our strategic plan, Doctors of BC has undertaken substantial work on the gender pay gap. We are the first provincial or territorial medical association to recognize the gender pay gap within our provincial Physician Master Agreement, we have a structure in place to provide individual Sections with data on their Section's gender pay gap, and we have committed funds to help reduce the gender pay gap. The General Surgeons of BC has already used these data to reduce its gender pay gap by a significant amount, although there is still room to do more.

While many health care systems, including BC's, are committed to equity, much work remains to be done. Many physicians continue to pinpoint a lack of equity as a prime cause of feeling disrespected at work and distrust the health care system's ability to protect them when they are victims of disrespect. Yet, because doctors love their work and their colleagues, they speak up when they are wounded. And it is this good faith criticism that reflects their belief that health care can be better for them and for the patients they look after. By employing the ideas and emotions that this good faith criticism raises, together we can create change and ensure accountability. But we can do this only by reminding ourselves and our colleagues that we are never alone, and that regardless of our differences, we can only be better together. ■

—Ahmer A. Karimuddin, MD, FRCSC
Doctors of BC President

Real-Time Virtual Support quick-reply pathways



Physicians working together to deliver equitable team-based care in rural BC.

B.R. Ohata, MD, CM, R. Connop Price, A. Yee, MD, I. Lupu, MD, N. Kitson, MD, PhD, D. Johnston, MD, J. Pawlovich, MD

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This article has been peer reviewed.

Background

Residents of rural, remote, and Indigenous communities in British Columbia face significant disparities in accessing quality health care services and professional supports. These well-documented disparities are particularly pronounced in Indigenous communities, where a history of inequitable and underprioritized access to health care resources has been observed.[1] In response to these challenges, the Real-Time Virtual Support (RTVS) program launched its quick-reply pathways starting in 2020 (during the pandemic) to provide a pan-provincial roster of specialist services.[2,3] The quick-reply pathways provide timely, video-enabled access to specialty expertise for health care providers, such as on-the-ground family physicians working on the front lines of rural, remote, and Indigenous communities.

RTVS quick-reply pathways are part of a larger network of rural video-enabled clinical supports, which also include emergency medicine (RUDi), maternity (MaBAL), and pediatric (CHARLiE) expertise. All providers strive to create a psychologically safe and supportive culture for clinicians to seek advice and exchange ideas. The "call a friend" culture of RTVS has made it easier for rural providers to reach out and advocate for patients who may need specialist care. Lowering barriers to access specialist support through the RTVS network can have significant positive influences on patient care and professional support.

Sample case

Here we explore a case that highlights the impact quick-reply pathways can have for patients and providers in rural, remote, and Indigenous communities.

A 66-year-old male presented to the emergency room in Fort Nelson, which is 800 km from the nearest tertiary care hospital. The patient told his family physician that he had been experiencing headaches, confusion, general unwellness, and a rash for 3 months.

Upon examination, the patient had a red, scaly, pruritic rash over his torso and limbs. There were no focal neurological deficits observed. Pertinent investigations

revealed positive SSA and SSB antibodies, hypocomplementemia, a decline in hemoglobin levels from 120 to 80 over 5 months, and an increase in creatinine levels from 69 to 110 over the past year, along with hematuria and proteinuria. At a previous visit, a skin biopsy had been performed, revealing vacuolar interface dermatitis consistent with a connective tissue disease–associated rash. As well, 1 month prior, the patient had been hospitalized at a different facility for cognitive decline so severe he couldn't speak or eat. During that admission, he was found to have diffuse symmetric white matter lesions involving the temporal lobes and sparing the corpus callosum on MRI. He improved with three doses of 1000 mg IV methylprednisolone but left hospital before further therapeutics could be initiated.

At this point, there was concern that the patient had neuropsychiatric lupus. Due to the complexity of the patient's case, his family physician sought assistance from RTVS quick-reply specialists. Over several days, guided by his family physician, the patient interacted with the RTVS dermatologist, rheumatologist, hematologist, and neurologist. After ruling out alternative autoimmune, infectious, and malignant diagnoses, a diagnosis of neuropsychiatric lupus was confirmed. The patient is now receiving definitive care and is on the path to recovery. He is free of headaches with no neurocognitive symptoms, but he does not recall the events of the previous 3 months.

For rural physicians, encountering patients with rare, multisystem diseases can be challenging, and the lack of support managing these patients can be frustrating. The virtual physicians on the other end of the Zoom or telephone call are committed to be friendly, culturally safe, compassionate, and dedicated to providing assistance wherever needed. According to this patient's family physician: "The help I received undoubtedly saved the patient from imminent decline. It was timely and effective. It was a real mountain of support for me, and in turn for the patient."

Conclusions

Access to specialists should not require years-long waits and marathon journeys on the part of rural patients. Specialists are distributed inequitably in British Columbia and tend to work in urban centres. It is incumbent upon us as physicians to devise innovative programs to address the gaps in care that arise from this uneven distribution of specialists. The RTVS program aspires to provide quality care to rural areas that have been historically underserviced. Because of RTVS, rural clinicians no longer need to feel isolated, managing challenging medical conditions they have never seen. As this case demonstrates, advice is only a Zoom call away.

RTVS quick-reply pathways are part of a larger network of rural video-enabled clinical supports, which also include emergency medicine (RUDi), maternity (MaBAL), and pediatric (CHARLiE) expertise.

Additional information

RTVS quick-reply pathways are supported by the Rural Coordination Centre of British Columbia (RCCbc) and receive approximately 153 calls per month. Family physician compensation for accessing the pathways varies depending on the physician's payment model. Specialists bill specialist advice codes or telehealth consultation codes for their interactions, depending on the nature of the encounter.

How to get involved

Rural family physicians can access the RTVS quick-reply pathways through the directory of their RCCbc Zoom account. Specialists interested in becoming involved can contact the corresponding author, Dr Ohata, at brent.ohata@ubc.ca.

To find out more and connect with RTVS, visit https://rccbc.ca/initiatives/rtvs/getting-started. ■

Competing interests

Drs Ohata, Yee, Kitson, Johnston, and Pawlovich, and Ms Connop Price all hold positions with the RTVS program.

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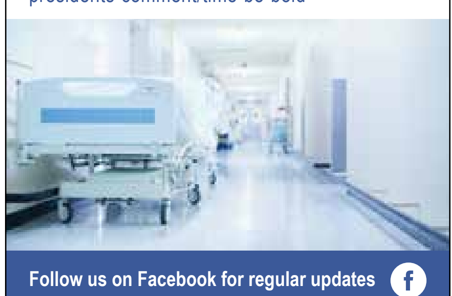

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What to consider when seeing patients with work-related health concerns

Four questions to help physicians consider the various aspects of work-related health requests and remind them of their roles and responsibilities.

Nikhil Rajaram, MD, FCFP, MPH, FRCPC, Sylvie Hudon, MD, FCFP, MSc(A), ACBOM, Marina Afanasyeva, MD, MPH, PhD, FRCPC

ABSTRACT: Many physicians have not received formal training in occupational medicine, yet they are often asked to help their patients with work-related concerns. Four general questions are presented for physicians to consider when dealing with such issues: (1) Beyond duties to the patient as part of the doctor–patient relationship, what other professional obligations exist? (2) What should and shouldn't be communicated to employers and other third parties? (3) Are there clear clinical justifications for all recommendations and notes provided? (4) Outside of clinical management, where can patients be directed for more help? Advice is offered to better explain the roles and responsibilities physicians may have in these encounters.

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This article has been peer reviewed.

Physicians are often the first, and sometimes the only, stop for patients who raise concerns about how their work may be affecting their health, or how their health may be affecting their ability to work. However, many clinicians have not received formal training in occupational medicine. Occupational medicine deals with the clinical, ethical, and legal considerations that often arise when dealing with work-related issues. These include physicians' reporting obligations, information sharing with employers and third parties, and workplace factors and systemic supports that influence a worker's ability to work safely. Four general questions are presented as a framework to use when managing a work-related issue for a patient.

Example scenario

A 25-year-old male with a 10-year history of type 1 diabetes presents with concerns that over the past few months he has had three episodes of feeling lightheaded and confused due to hypoglycemia at work. While the focus of the visit is on reviewing the patient's self-management and medications, he is asked what he does for work. (He operates a forklift at a furniture warehouse.)

Question #1: Beyond duties to the patient as part of the doctor–patient relationship, what other professional obligations exist?

It is generally expected that physicians put patients' needs first when addressing their health-related requests. However, in some situations, the distinction between patients' wants, patients' needs, and societal needs becomes important. When patients request clinically inappropriate tests or medications, such as an MRI of the spine for acute mechanical back pain without any red flags or antibiotics for an uncomplicated viral upper respiratory tract infection, it is a physician's duty to be guided by evidence and avoid ordering unnecessary tests and treatments. This is done to prevent harm to a patient (e.g., misleading incidental MRI findings or side effects of antibiotics) and to society (e.g., unjustified strain on health care resources or risk of antimicrobial resistance). Similar considerations matter when dealing with requests related to return to work.

Consider that the patient in the example scenario was temporarily taken off forklift duty following an incident where he lost consciousness at work. He now wants to be cleared to return to work as an operator of

heavy equipment, yet it is determined that he remains at risk of future hypoglycemic episodes, which could lead to sudden loss of consciousness on the job. He takes pride in his work and may risk a partial or total loss of income depending on his contract. His physician wants to support him in being able to return to full duties as a forklift operator (patient's want) but should also consider the risk of the patient endangering himself (patient's need) and others (societal need) as a result of sudden incapacitation. Operating a forklift is a safety-sensitive job, which is a position that "if not performed in a safe manner, can cause direct and significant damage to property, and/or injury to the employees, others around them, the public and/or the immediate environment."[1] Careful consideration of an appropriate interval of time is required before clearing the patient to perform safety-sensitive tasks as a forklift operator, including his adherence to his treatment plan and when the last episode of hypoglycemia occurred. For some tasks, there may be prescriptive requirements for return to work set by the employer or related professional bodies. When there is no specific medical guidance for a safety-sensitive job, it is reasonable to consider the Canadian Medical Association's Driver's Guide[2] when assessing patients' fitness to perform safety-sensitive tasks and fulfilling professional College of Physicians and Surgeons of BC reporting obligations.

If this patient worked in a specialized environment, this might require additional expertise. For example, the Aeronautics Act[3] requires physicians and optometrists to inform aviation medical advisors of conditions likely to constitute a hazard to aviation safety. Another example would be a patient who requests a certificate clearing them to work as a commercial diver—physicians conducting such examinations require advanced training to meet standards for safety (such as CSA Z275.2 for occupational diving operations,[4] written by CSA Group). In British Columbia, the requirement for knowledge and competence in diving medicine is outlined in Section 24.10 of the Occupational Health and Safety Regulation, and WorkSafeBC keeps a list of physicians that are recognized as possessing such knowledge and competence.[5]

The purpose of asking this question is to consider all professional obligations and determine if one is capable of fulfilling the patient's request or if another health care provider with the required expertise should be making these determinations instead.

Occupational medicine deals with the clinical, ethical, and legal considerations . . . These include physicians' reporting obligations, information sharing with employers and third parties, and workplace factors and systemic supports that influence a worker's ability to work safely.

Question #2: What should and shouldn't be communicated to employers and other third parties?

All physicians are well trained in the importance of safeguarding personal health information. In BC, physicians must adhere to the Freedom of Information and Protection of Privacy Act when communicating with employers. Although it is reasonable to question any unauthorized attempts from a third party to access a patient's chart, it is important to consider the following. First, workplaces need enough information to know how to accommodate and/or safely return a patient to work by modifying any combination of that patient's work duties, work environment, and work schedule. This does not require providing diagnostic or therapeutic information, but rather a description of the patient's level of functioning. In the example scenario, an employer does not need to know about a worker's diagnosis of diabetes but does need to know about the functional impacts associated with the condition (e.g., risk of loss of consciousness if glucose control is not optimal, requirements for additional breaks).

The Canadian Human Rights Commission's *Guide for Managing the Return to Work*[6] states that, in general, work supervisors are entitled to know how an employee's health could affect their ability to complete job duties, whether it is temporary or permanent, and whether the employee has the ability to perform alternative work. The Canadian Medical Association has guidance on third-party forms that describes in greater detail physicians' roles and responsibilities related to this.[7]

Some workplaces have occupational health professionals (including occupational physicians) who are bound to keep confidential all health information and records they receive from external health care providers that are not shared with management. These health professionals are not typically considered part of the circle of care, but they play an important role in workplace accommodation if they are able to review pertinent health details the employer must not access. If workplaces have safety-sensitive jobs, their occupational physicians may be responsible for clearing workers for duty, requiring detailed medical information to make this determination. When drafting a report for a workplace, it is important to understand who the reader will be. If the report is for the worker's supervisor, manager, or employer, the report should be limited to information regarding the worker's functional abilities and any medical limitations or restrictions. If the report is intended for an occupational physician, it may be helpful to provide medical information, with the patient's consent. CSA Z1011:20: Work Disability Management System recommends that any such information be shared only with staff who are subject to a recognized professional health care code of ethics.[8]

Question #3: Are there clear clinical justifications for all recommendations and notes provided?

When a patient has concerns about an

exposure or circumstance at work affecting their health and wants a remedy for this, it is important to first confirm a diagnosis that explains their symptom presentation (if any); understand what their illness experience has been and why they think it is related to work; and then consider the extent to which this could be caused by, be exacerbated by, or interfere with work. To make these determinations, it is important to identify hazardous exposure(s) in the workplace.

If patients expect a certain remedy (e.g., a note for the workplace requesting a specific accommodation), it helps to understand what they expect as they recover from their illness or injury and the implications of granting their request. One of Choosing Wisely Canada's recommendations for occupational medicine is "Don't endorse clinically unnecessary absence from work," citing both the positive link between work and health as well as the potential risk of creating further disability where such an endorsement lacks detail about a patient's abilities and medical limitations or restrictions.[9] Employers may also have concerns with the costs associated with absenteeism. Notes stating that a patient requires absence from work should be for the minimum necessary duration, and a clear rationale should be documented in medical records. In many cases, a complete absence from work is not needed where medical limitations or restrictions can be accommodated. For the example patient who is a forklift operator, a note to the employer could say "Unable to operate heavy machinery" instead of "Unable to work." In many situations, it would be helpful to state what the patient *can* do—for example, "Able to do sedentary work or physical work not involving operation of heavy machinery." The note should clearly state the duration of the restriction and when the patient is expected to be reassessed. To reduce the risk of prolonged worklessness, the BC Workers Compensation Act was amended as of 1 January 2024 to introduce new duties for employers and workers to ensure their cooperation during the return-to-work process after a work-related injury or illness.

When communicating with an employer about a patient's ability to work, it is important to describe medical limitations (i.e., what a patient is unable to do because of a medical condition—the opposite of the patient's abilities) and restrictions (i.e., what a patient should not do due to risk to their health or, if a safety-sensitive position, risk to others) that the employer can use to determine an appropriate accommodation in the workplace. Physicians and patients generally do not know what accommodations an employer can provide to workers. Given this, a physician's note to an employer about medical limitations or restrictions should focus on what a worker can and cannot do, while avoiding specific statements about how exactly the worker should be accommodated. Some larger employers have designated staff trained to create fair and supportive accommodation plans for recovering employees. A clear outline of a patient's abilities and medical limitations or restrictions is helpful in creating these plans. In some situations, physicians may be asked by an employer to provide details about medical limitations or restrictions that physicians are unable to answer. In these cases, a note should state what can and cannot be assessed and suggest a referral to a specialist or clinic that performs functional capacity assessments, neuropsychological testing, or an independent medical evaluation.

Question #4: Outside of clinical management, where can patients be directed for more help?

Occasionally, patients consult physicians about situations that require individuals from outside the health care sector to be involved. For example, harassment and bullying or interpersonal conflicts in the workplace may be better addressed by the employer using an administrative venue, while physicians focus on the impact of the situation on the patient's health.

Physicians may understand the health care system but know little about the occupational health and safety system in their jurisdiction, and they may not be aware of applicable resources. Most jurisdictions have health and safety regulators (who enforce laws to protect workers), workers' compensation boards (that adjudicate claims for occupational illnesses and injuries and provide educational resources and information), and associations that provide assistance to workers (e.g., unions, legal clinics, occupational health clinics). In BC, WorkSafeBC functions as both health and safety regulator and workers' compensation board.

There are also other public agencies that provide a wealth of information on occupational health concerns. For example, the Canadian Centre for Occupational Health and Safety (www.ccohs.ca) produces resources on workplace health and safety and prevention of work-related injuries, illnesses, and deaths. It may be beneficial to learn about the organizations that exist in your jurisdiction to help support patients on issues outside a physician's scope of practice. WorkSafeBC provides resources for health care providers on its website: www.worksafebc.com/en/health-care-providers.

Conclusions

Answers to the four questions presented here are not always straightforward, but they warrant careful, considered thought when they arise during clinical encounters in primary care. By thinking through these questions in cases that may be work-related, physicians can give themselves some peace of mind knowing they've done as much as they can to support their patients while also meeting their professional obligations. ■

Competing interests

None declared.

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Ultrasonographic findings and treatment in heterotopic cesarean scar pregnancy

A very rare case of heterotopic cesarean scar pregnancy highlights the potential for cesarean scar pregnancy in patients with a history of cesarean scar.

Samantha R. Saravana-Bawan, MD, FRCP, Karen Letourneau, CRGS

History

A pregnant woman in her mid-30s presented to the emergency room with acute onset of back and pelvic pain and moderate spotting. The patient was gravida 4, para 2 (G4P2) and had had two prior cesarean sections. The pregnancy was conceived using letrozole as a fertility medication, which has a known twin risk of 3% to 7%.[1] Estimated gestational age was 5 weeks 3 days. Quantitative β-hCG level was 7190 mIU/mL at presentation and rose to 13 484 mIU/mL 2 days later.

Imaging findings

Ultrasonography showed a gestational sac with an embryo implanted in the endometrium near the fundus and an ectopic gestational sac within the cesarean scar niche **[Figure]**.

Dr Saravana-Bawan is an interventional radiologist in the Island Health Authority. Ms Letourneau is a sonographer in the Island Health Authority.

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This article has been peer reviewed.

Discussion

Imaging findings of two gestational sacs, where one sac is implanted along the cesarean scar, suggests heterotopic cesarean scar pregnancy. The patient wished to keep the intrauterine gestation; thus, a selective reduction of the cesarean scar pregnancy by ultrasonography-guided local injection of methotrexate was performed. Despite this, the patient's β-hCG level continued to rise. Systemic treatment with methotrexate also failed to reduce the β-hCG level; therefore, a hysterectomy was performed. Heterotopic cesarean scar pregnancy was confirmed at pathology.

Heterotopic pregnancy is one of the rarest forms of multiple gestation, occurring in less than 1 in 30 000 naturally conceived pregnancies.[2] The incidence of heterotopic pregnancy increases with assisted reproductive techniques.[3] Cesarean scar pregnancy is extremely rare and accounts for only 6% of all ectopic pregnancies; however, incidences are rising with cesarean section rates.[4] Heterotopic cesarean scar pregnancy is a rare cesarean scar pregnancy combined with an intrauterine pregnancy.

Treatment for isolated cesarean scar pregnancy includes dilation and curettage, laparoscopic resection, and local or systemic administration of methotrexate.[5] Because of the low incidence of heterotopic cesarean scar pregnancy, no standard treatment protocols have been established. Ultrasonography-guided selective embryo aspiration and/or drug injection and surgical resection have been described.[6] ■

Competing interests

None declared.

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U/S probe
GS in C-section scar
Cervix
GS normal implantation
Bowel
Fundus

LOGIC E10
C-section scar
Yolk sac
Embryo
Fundus
Bowel

FIGURE. Sagittal transvaginal grayscale image of the uterus, showing two gestational sacs, with a clarifying graphic above. An embryo is present in the gestational sac, normal implantation; a yolk sac is present in the ectopic cesarean scar gestational sac (arrows). U/S = ultrasonography; GS = gestational sac.

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Eliminating the routine use of examination table paper in outpatient oncology clinics

Cost savings and greenhouse gas emission reductions can be achieved by eliminating the use of examination table paper in clinics.

ABSTRACT

Background: Health care systems contribute significantly to greenhouse gas emissions. One source of these emissions is single-use products. Examination table paper does not confer protection against microbial contamination and thus can be omitted while following infection control standards. The objective is to eliminate the routine use of examination table paper in outpatient oncology clinics at BC Cancer.

Methods: A quality improvement approach was used. Examination tables continued to be disinfected using wipes between patients, but table paper was not used. Plan-do-study-act cycles were performed at four regional cancer centres.

Results: Pre-intervention, the cancer centres used 19 to 69 rolls of paper monthly. Post-intervention, usage declined to 0 to 2 rolls monthly. This was associated with annual cost savings of $3974 and a reduction of 32 501 kg of carbon dioxide emissions.

Conclusions: The use of examination table paper can be eliminated in outpatient clinics, resulting in both cost savings and a reduction in carbon dioxide emissions.

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Background

Climate change is a continuously growing threat, and the resulting environmental and societal instability significantly impacts not only human health but also the health care sector as a whole. As the climate continues to destabilize, extreme weather events disrupt services and infrastructure, superbugs increase in prevalence, and food security is threatened.[1] In their current state, the health care sector's operations exacerbate the climate crisis by generating vast waste and engaging in carbon-intensive practices, which creates a detrimental feedback loop.[2]

The health care sector contributes approximately 5% of the world's greenhouse gas emissions, which emphasizes the pivotal role that implementing low-carbon, low-waste health care practices plays in mitigating climate change. Emissions from providing health care are grouped into three categories, as defined by global greenhouse gas accounting standards. Scope 1 includes direct facility emissions, such as those from fossil fuel heating systems and anesthetic gases. Scope 2 includes indirect emissions from energy purchased—typically electricity. Scope 3 includes emissions attributed to the global health care supply chain, which represent 60% to 80% of health care–related emissions. This includes the production, transport, and disposal of goods such as pharmaceuticals, food, medical devices, hospital equipment, and instruments.[3-5]

Covering clinical examination tables with thin white paper (referred to as table paper) is an example of a wasteful practice involving a single-use item. This practice has become entrenched in outpatient clinical care. Typically, a roll of paper is attached

to the table, and the paper is changed after every patient. Although the paper may be recyclable in some jurisdictions, most commonly it is thrown into standard garbage due to fears of microbial contamination. Its presence conveys the appearance of a sterile medical environment. However, it adds no protection against surface-borne bacteria or viruses.[6,7]

While ample data indicate that surfaces such as examination tables can harbor microbes,[8-10] infection control guidance recommends cleaning surfaces with hospital-grade disinfectants between patients. The use of a barrier, such as table paper, does not replace the need for cleaning.[11-13] Elimination of table paper has been subject to a number of sustainable quality improvement initiatives.[14-16] To our knowledge, this had not been implemented in large ambulatory care centres or in centres that routinely care for immunocompromised patients.

In the past, examination tables in the ambulatory clinics at BC Cancer were cleaned with disinfectant wipes between patients, followed by a change of the table paper. Several clinicians noted that this practice resulted in unnecessary waste and effort. The concern was escalated to the BC Cancer Planetary Health Unit, a clinician-led initiative focused on promoting low-carbon, low-waste, and high-quality sustainable health care practices. Under the leadership of the BC Cancer Planetary Health Unit, a sustainable quality improvement project was developed to eliminate the routine use of table paper in outpatient oncology clinics.

Methods

Context

British Columbia has a population of 5 million people, and more than 30 000 new cancer diagnoses are made in the province yearly. BC Cancer is a population-based provincial care system that provides oncology services to the residents of BC. The system consists of six regional cancer centres. The largest facility, BC Cancer – Vancouver, has 80 beds that are used for ambulatory care visits.

A multidisciplinary team comprising clinical experts, primarily from the first and largest study site (the Vancouver centre); operations leaders at the provincial and regional centres; and ambulatory clinic managers adopted a quality improvement approach to eliminating the routine use of table paper in outpatient oncology clinics. This involved problem identification, setting targets, measuring success, testing changes using plan-do-study-act cycles, and eventually standardizing the change. Local and infection prevention and control services supported this initiative.

The health care sector contributes approximately 5% of the world's greenhouse gas emissions, which emphasizes the pivotal role that implementing low-carbon, low-waste health care practices plays in mitigating climate change.

Study design

A literature review and workflow mapping were conducted. Redundancy in the existing process was identified: exam table paper was used after the table was cleaned with disinfectant wipes.

A before-and-after study design was employed. To address the impact of reduced in-person clinic visits due to COVID-19, we expanded the pre-intervention period. Pre-intervention data extended from 1 January 2019 to 30 June 2022; post-intervention data extended from 1 July 2022 to 30 June 2023. Two regional centres were excluded: one did not use exam table paper; the other had not implemented the change in procedure during the evaluation period.

Interventions

The first plan-do-study-act cycle occurred at BC Cancer – Vancouver, and then was replicated at three other centres: Kelowna, Victoria, and Surrey. The project team planned the change in procedure with cleaning staff. A new standard workflow was implemented: table paper was removed, and staff were required to wipe the exam table after each patient appointment. Table disinfection rates and practices were not deliberately modified as part of the intervention. Information posters explaining the intervention and rationale for its use were placed in examination rooms **[Figure 1]**. The posters included an email address for patients and providers to provide feedback about the intervention and a QR code that linked to infection control documents for patients or staff who desired more information. For patient comfort, table paper was still available upon patient or health care provider request.

Assumptions

BC Cancer, a program of the Provincial Health Services Authority, procures medical supplies through Provincial Health Services Authority centralized procurement. In this study, monthly quantities of rolls of table paper purchased served as a proxy for usage. A run chart that displayed the data was used to identify trends and shifts in usage.

Due to limitations in the available data, the amount of carbon dioxide (CO_2) emissions saved by eliminating the use of table paper was calculated based on the following assumptions:

1. The emission factor of table paper is equivalent to that of office paper. This assumption was based on aligning paper types with known emission factors. The *2020 B.C. Best Practices Methodology for Quantifying Greenhouse Gas Emissions*, published by the BC Ministry of Environment and Climate Change Strategy, provides established emission factors for office paper. While exam table paper might have distinct properties, using the office paper emission factor offered a pragmatic approach to determining approximate emissions.[16]

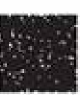

FIGURE 1. Poster used in exam rooms at BC Cancer – Vancouver during the intervention period.

TABLE. Pre- and post-intervention paper use, cost savings, and reductions in carbon dioxide (CO_2) emissions.

	Median monthly paper usage (number of rolls)		Yearly cost savings ($)	Yearly reduction in CO_2 emissions (kg)
Centre	**Pre-intervention**	**Post-intervention**		
Vancouver	36.0	0	726	7 156
Kelowna	19.0	2	355	3 379
Surrey	69.5	0	1451	13 816
Victoria	41.0	0	1442	8 150

2. Exam table paper is a 0% post-consumer recycled product. Given that manufacturers often market recycled paper as a selling point and charge a higher price for such products, it is reasonable to conclude that a lower-priced product likely does not have any recycled content unless specified.

Statistical analysis

Microsoft Excel was used to generate run charts. To identify trends and deviations in the data, we computed the median value of monthly purchases of table paper and incorporated a median line into the chart. Statistical rules for detecting special cases encompassed a run consisting of seven or more consecutive points on either side of the median line, a trend consisting of seven or more consecutive points moving upward or downward, too few or too many runs, or astronomical data points.

To quantify CO_2 emissions, we first calculated the total number of table paper rolls saved from July 2022 to June 2023 and estimated the equivalence to the number of 500-sheet 11″× 17″ office paper packages. Subsequently, we determined the cumulative weight of the office paper packages based on the manufacturers' information. Finally, we used the *2020 B.C. Best Practices Methodology for Quantifying Greenhouse Gas Emissions* for office paper to compute the overall emission savings.[16]

Results

The Vancouver centre commenced eliminating the use of table paper in June 2022. Continuous monitoring and feedback from frontline staff revealed no major issues; thus, the change was implemented in the other three centres by December 2022.

At the Vancouver centre pre-intervention, 36 rolls of table paper were used monthly; post-intervention, no table paper was used. This translated to a savings of $726 and a reduction of 7156 kg of CO_2 emissions per year. Similar observations were noted post-intervention at the other three centres **[Table]**. No table paper purchases were recorded for the Vancouver and Victoria

centres after November 2022, indicating a sustained change after the intervention period.

The run charts exhibited desired shifts in the use of table paper in all four centres [Figure 2]. The significant reduction in paper usage from April 2020 to June 2021 was due to the decrease in ambulatory visits during the COVID-19 lockdown.

No direct feedback about the intervention was received from patients; however, feedback from providers was largely positive. Some providers remarked that older exam tables had become sticky with exposure to chemical-grade disinfectant wipes over time. Table paper continued to be used on those tables until they could be replaced.

Discussion

Our study demonstrated the feasibility of implementing a large-scale, sustainable, quality improvement initiative, which achieved both cost savings and a reduction in CO_2 emissions. The intervention was largely successful, with nearly zero usage of table paper post-intervention. The total of 32 501 kg CO_2 emissions avoided though this initiative is equivalent to driving 134 087 km in an average gasoline-powered passenger vehicle.[18] Although a number of health care sustainability teams have initiated similar projects, to our knowledge this is one of the largest such initiatives and the only one to include a substantial population of immunocompromised patients.

The study had additional benefits for our centres. Although not measured in this study, we observed decreased workload for care aides, because they were no longer faced with the extra task of changing the table paper. A similar small project in a university health centre found that cleaning time was reduced by more than half when table paper was omitted.[15]

The dramatic and sustained decrease in table paper purchasing demonstrates the cultural shift that occurred with the intervention. Although table paper was still available for patients and clinicians to use, it was easily recognized that it ultimately provided no value in our clinics. Although

FIGURE 2. Run charts of monthly table paper usage, by centre, January 2019 to June 2023: (A) Vancouver, (B) Kelowna, (C) Victoria, (D) Surrey.

we did not receive any direct feedback from patients, the low usage of paper after the intervention suggests that they were supportive of the intervention. Although there was some initial concern from clinics about cases where bodily fluids could be released during physical examinations, absorptive pads and washable surgical cotton cloths proved to be more suitable alternatives to table paper. The elimination of table paper and the associated posters also provided a visual reminder of work being done by the BC Cancer Planetary Health Unit. The availability of the contact information on the posters allowed clinicians to contact the project team, provide feedback, and suggest other initiatives.

Study limitations

We did not measure any balancing metrics because the standard practice at our facilities was to wipe tables in addition to using table paper. Table disinfection rates were not measured as part of the intervention. However, we recognize that in many ambulatory settings, table paper is used as a "marker" of whether the table has been used during a clinical encounter. Thus, it is possible that wipe usage increased. Because of the variety of disinfectant products used and multiple uses of the wipes, it was not possible to easily capture these data using procurement data. We also were not able to accurately measure whether the usage of other products such as disposable absorptive pads or bedsheets increased post-intervention.

We recognize that the practice of wiping tables and other medical equipment with single-use products between patients in the ambulatory setting, while compliant with infection control standards, creates large volumes of waste. In addition, the regular use of disinfectant wipes may quickly degrade the table surface, which may result in replacement of the equipment sooner than usual. Our project team hopes to explore alternatives to this practice to help reduce this burden. For example, the use of ultraviolet light has been shown to reduce microbial contamination on medical equipment without the need for manual disinfection.[19] Biodegradable wipes and wipes with recycled content are also becoming increasingly available on the market.

In addition, potential bias may have been introduced by the adoption of virtual clinic practices. The COVID-19 pandemic has had a substantial impact on health care practices, including outpatient visit patterns. The decrease and subsequent increase in in-person outpatient visits due to lockdowns and subsequent changes in health-seeking behaviors could have confounded the observed trends in the usage of exam table paper. However, the use of virtual clinics aligns with the larger project objectives in that CO_2 emissions are reduced due to a decrease in the use of table paper and the use of transportation to attend clinics.

Our study demonstrated the feasibility of implementing a large-scale, sustainable, quality improvement initiative, which achieved both cost savings and a reduction in CO_2 emissions.

Finally, in calculating the reduction in CO_2 emissions, we had to make several assumptions. Without readily available information on the recycled content of exam table paper, it is reasonable to assume that it is 0% post-consumer recycled, but this may result in an overestimation of the environmental benefits of eliminating its usage. However, this approach aligns with common practice in quality improvement outcome assessment when precise data are lacking.

The exclusion of two regional centres from the study highlights potential improvement opportunities. One centre, the newest in the system, had never used exam table paper. This highlights the importance of taking a more proactive approach to waste management in health care. The other centre delayed the change in using exam table paper because additional time was required to map the new operational flow in the clinics. Nevertheless, these challenges have been managed, and the change is expected to take place in the next 6 months.

Conclusions

We hope that our project will inspire other centres to initiate the change from using paper on examination tables. The recognition of this wasteful practice by a small group of clinicians ultimately catalyzed a change across hundreds of clinic rooms. There is much more work to do to decarbonize the health care system. A collective and collaborative global effort is required to invoke the necessary shifts in norms, policies, and investments.[2] Various credible examples of mitigation tactics have been used worldwide, ranging from low-carbon or renewable energy strategies to changes in the use of single-use items in clinical practice.[20] The cumulative effects of individual and collective efforts are vital to relieving the consequential impacts of climate change. ■

Competing interests

None declared.

Acknowledgments

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Anna Mason, MD, Kristin Atwood, PhD, Frieda Hodgins

Impact of the family physician shortage on BC specialists' health and well-being

Specialist physicians have experienced negative effects on their health, career plans and trajectory, and professional and personal relationships due to the family physician shortage.

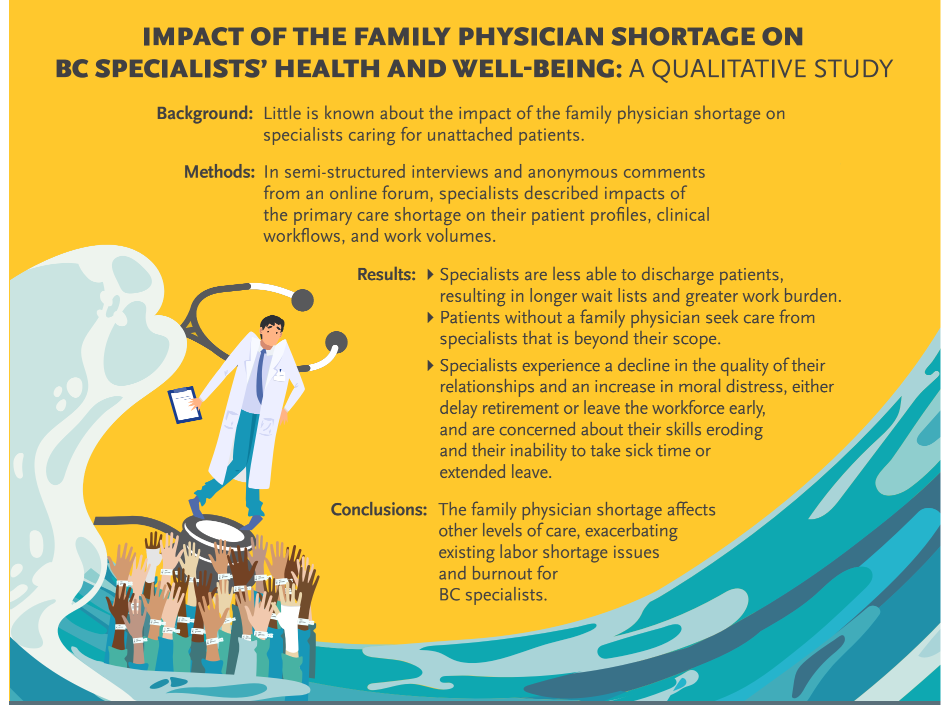
ABSTRACT

Background: Little is known about the impact the shortage of primary care physicians has on specialists who are caring for patients who do not have a family physician.

Methods: This qualitative study involved semi-structured interviews with 37 specialists in Victoria, British Columbia; an additional 21 specialists provided written comments anonymously in an online forum. Participants were asked to describe the impact the shortage of primary care physicians has on their patient profile, clinical workflows, and work volumes.

Results: Participants reported an increase in the number of patients who do not have a primary care physician. This has affected specialists' ability to discharge patients, which has resulted in longer wait lists and a greater work burden. Additionally, patients who do not have a family physician seek care from specialists that is beyond the scope they can provide. Participants also reported a decline in the quality of their professional and personal relationships and an increase in moral distress; some stated they were delaying retirement or leaving the workforce early and were concerned about the erosion of their skills and the ability to take sick time or extended leave.

Conclusions: The shortage of primary care physicians has ripple effects on other levels of care. This exacerbates existing issues related to labor shortages and burnout for specialists practising in BC.



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Background

The ongoing shortage of family physicians who provide primary care is well documented, and concerns about the implications for patients have become increasingly urgent.[1-3] However, little attention has been paid to how this shortage affects specialist physicians. Specialist and primary care services are complexly intertwined. Specialists rely on family physicians to appropriately

refer patients and to continue care after specialized services conclude. Specialists are already facing high levels of burnout and dissatisfaction with work–life balance, which has intensified due to the COVID-19 crisis.[4-6] The family physician shortage exacerbates existing capacity strains, especially when specialists find the care they can provide is less effective than it ideally would be.[7]

When specialists experience moral distress, they are more likely to leave medicine, which erodes the robustness of the physician workforce.[8,9] They are also more likely to disengage from patient-centred care, such as by avoiding or abbreviating tasks related to patient communication.[10] It is only through understanding the specific impacts of the family physician shortage on specialists that this negative spiral can be mitigated. We describe changes in the scope and volume of specialist work due to the increase in the number of patients who do not have a family physician and link these changes to outcomes for specialists' relationships, career experiences, and personal and familial health.

TABLE 1. Number of study participants, by specialty.

Specialty	*N**	Specialty	*N**
Psychiatry	10	General surgery	< 5
Pediatrics	8	Hospitalist medicine	< 5
Oncology	6	Neurology	< 5
Addictions medicine	< 5	Obstetrics/gynecology	< 5
Anesthesiology	< 5	Orthopaedics	< 5
Cardiac surgery	< 5	Palliative care	< 5
Cardiology	< 5	Respirology	< 5
Emergency medicine	< 5	Urology	< 5
Endocrinology	< 5	Specialty not indicated	10
Gastroenterology	< 5	Total	58

* Exact numbers are not provided for specialties with fewer than five participants. To support confidentiality, interview and online forum participants are combined.

BOX. Interview and online forum questions

1. **Interviews:** The following questions were included in the interview guide. The interviewer had leeway to follow the course of the conversation with additional questions as seemed appropriate.
    - What was it that caught your eye and made you respond to our project?
    - Can you share some examples or stories about patients you have treated who do not have a family physician and how this has impacted their care?
    - Have you found that the family physician shortage has impacted your practice? For instance:
        - How has your scope of practice changed?
        - How has the morbidity or mortality of your patients differed?
        - How have transitions of care been affected?
2. **Online forum:** Because the online forum was a more passive environment where no follow-up was possible, a more general prompt was provided in the hopes of eliciting a broad range of responses:
    - How has the BC primary care crisis affected your practice?

Methods

This research was conducted in Victoria, British Columbia, between February and May 2022. Participants were recruited via postings in the local Medical Staff Association newsletter, which has an estimated readership of 500 physicians. The sample was self-selected. Ethical considerations were part of the funding approval process through the Medical Staff Association's review of the proposed project.

Two methods were used: qualitative semi-structured interviews (37 individuals) and an anonymous online forum (21 individuals, likely unique from those who participated in the interviews). A wide range of specialties (18) were represented, but there was clustering in pediatrics, psychiatry, and oncology, all of which have frequent interactions with primary care **[Table 1]**.

In both methods, participants were asked how the family physician shortage has affected their patients, practice, and well-being. They were also asked to estimate the proportion of their patients who did not have a family physician. The interview questions and forum prompts are provided in the **Box**.

Interviews were transcribed. All co-authors reviewed the first 10 interviews individually and identified initial themes, which were then discussed and finalized before one co-author analyzed the remainder of the responses. There were few discrepancies in coding, and they were resolved through consensus. Ensuring intercoder agreement enhanced the trustworthiness of the thematic coding. Thematic analysis was guided not by a priori theorization but rather by a pragmatic, descriptive approach.

As with all qualitative research, researcher characteristics inform interpretation. In this case, researcher characteristics were diverse and brought unique perspectives to the project. The team consisted of a medical student, a family physician, and an applied sociologist, each of whom had their areas of expertise and "blind spots" that could be addressed by the others. This allowed for a full exploration of themes in the data as they emerged.

Results

All participants indicated that the proportion of their patients who did not have a

family physician was increasing over time. Self-reported estimates ranged from 10% to 65%, with a median of 50%.

Specialists reported that patients who did not have a family physician were significantly further along in their disease state at initial referral than those who had a family doctor. In addition, specialists were unable to discharge patients who needed ongoing monitoring but not ongoing specialized services, and they had to provide a greater proportion of primary care within their specialty than they had previously done. The **Figure** represents the scope and workload pressures that participants identified.

As a consequence of these pressures, participants reported effects on their well-being in terms of relationship quality, career experiences, and personal health **[Table 2]**. These were not mutually exclusive; they exacerbated one other. First, the quality of their relationships with patients, colleagues, and loved ones had declined. In terms of career experiences, specialists were reducing the scope of services offered, delaying retirement, or exiting the workforce early. They also worried about the possible erosion of their specialized skills. Finally, they experienced health impacts, including a lack of access to primary care for themselves, an inability to take time off work for illness or long-term absences such as parental leave, and an increasing sense of moral distress and injury.

Discussion

The family physician shortage has led to bottlenecks in discharging patients, ballooning wait lists, and a heavier and more complex workload. This results in negative outcomes for specialists individually, including declining quality of relationships with others, both personal and professional; effects on their career plans and trajectory; and negative health outcomes, particularly moral distress and injury. Because many specialties also face physician shortages, the lack of primary care physicians may exacerbate existing workforce pressures in specialist services.

Despite the interconnectedness of the health care system and the general awareness of the family physician shortage, few studies have examined the ripple effects on specialists. However, heavier specialist workloads have been shown to be associated with more errors.[11] Lack of primary care capacity has been identified as a barrier to implementing care models that could improve the sustainability of the specialist workforce.[12] In addition, physicians tend to respond to resource limitations by "going above and beyond the call of duty," which puts them at further risk of burnout.[13] The participants in this study work in an interdependent health system; therefore, the lack of family physicians has created ongoing and increasing challenges in their work and personal lives.

Study limitations

This study was limited by the self-selection of participants, who may have chosen to participate specifically because they were experiencing negative impacts related to the family physician shortage. Therefore, the findings cannot be generalized to the specialist population. Because this research is qualitative, a direct causal relationship between the family physician shortage and participants' experiences of negative

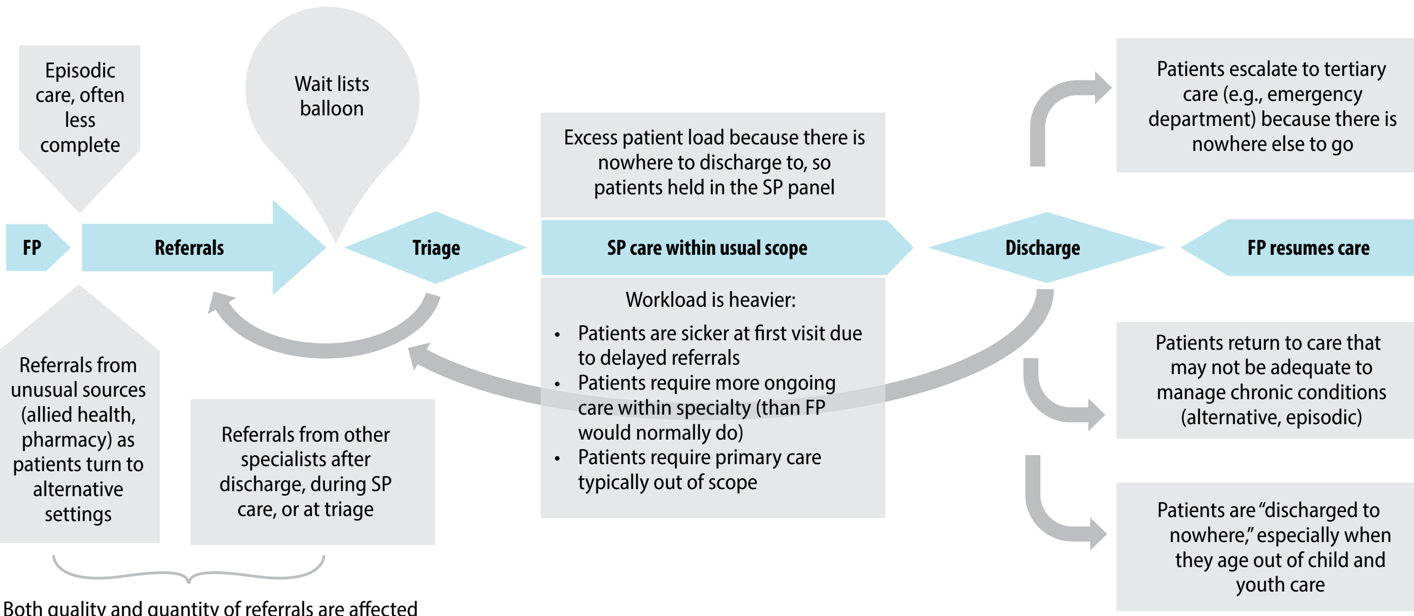

FIGURE. Impacts on specialist physician workflows due to increased numbers of patients who do not have a family physician. The blue boxes indicate expected patient flow when the system is well resourced; the gray boxes indicate workflow issues related to a lack of primary care physicians (FP: family physician; SP: specialist physician).

TABLE 2. Key themes and illustrative quotations regarding specialists' relationship quality, career experiences, and personal health outcomes related to the family physician shortage.

Area	Key theme	Illustrative quotation
Relationship quality	Patients	It's demoralizing to be disappointing people . . . it's me in the room, with the patient saying no . . . it just contributes to exhaustion and fatigue and burnout . . . with people super angry about . . . not being admitted [into our service]. That just contributes again to distress and burnout in the department. Because it's [not] like . . . we don't know. There's no individual in our department who's standing there cackling with an evil laugh being like "I'm going to deny you care." There's nothing to offer.
	Colleagues	It keeps funneling up and up, and you lose your collegiality and your working relationships with these other colleagues, and you start to feel very isolated and alone in your practice. Where before . . . there'd be much more of a feeling of working together, [now] it much more has a sense of "This is your problem; you deal with it . . . I've got a million other things to deal with." So, you lose that creativity that [comes from a team].
	Loved ones	Every day, I'm wrestling with this knowledge of I have to balance my relationship with my kids, who I love desperately, and I want to be with, with my commitment and responsibilities for work. So, I come home at 6:30, and it's like 45 minutes before my kids are in bed, or an hour . . . This morning, I was up at 6:00, doing paperwork and dictations. So, I'm busy while they're getting ready for school . . . how can I be the parent that I thought I was going to be? We never wanted to be on the hamster wheel. We wanted to have good work–life balance. I only wanted to work four days a week. Be home at 5:00. Be that attentive parent.
Career experiences	Reduction in services	I work in [a program] that's mandated for 3 years. I have patients that have been in the program for 5 years. And I can't discharge them from our service . . . I'mthinking, do I have to quit one of my jobs to be able to service the patients that shouldn't be there? So, do I need to quit my acute care job? . . . I've probably cut back on 50% of the [other] outpatient work I do because the areas just keep filling up . . . the next consequence, like I said, would be probably quitting one of my other jobs.
	Delayed retirement	Another colleague of mine . . . has abruptly gone half time and will probably do another year and then quit. Another colleague is reducing her time. And I have two more that are already down to 0.8, one of whom will be going down to half time . . . [My retirement] was a recent decision, because I needed to wait until we had somebody that could cover. I wasn't going to retire without a replacement, because that's a lot of additional work then that other people have to do.
	Early exit	I feel like I'm in a health care system with the wheels coming off. And I'm actually worried about what things are going to look like 5, 10 years down the road. It makes me feel uneasy, and it sort of makes me wonder. Sometimes I find myself thinking, looking for an exit strategy. And I really love my job.
	Erosion of skills	I have felt that transition of how much time I spend seeing . . . patients who are not acutely sick and requiring resuscitative care, and I think . . . there's only so long you maintain skills that you're not using . . . there could be unintended consequences in the long term of what happens to these physicians like me who are just not seeing that volume [of true emergencies].
Personal health outcomes	Lack of access to primary care	Honestly, even just for myself, if we have any health problem in our family, I have absolutely no idea how I would get care for anybody in my family without going to [Emergency], because you look on walk-in clinic wait lists, and they're done by eight o'clock in the morning. They're full for the day.
	Ability to take sick time	I still worked from home . . . 9 hours virtually, super sick. And so, the stress of taking time off is pretty big . . . unpredicted time away, it's just so stressful, like you just can't do that. Like I don't get to stay home if my kids are sick . . . I can't not be at work unless it's an absolute crisis.
	Ability to take leave	When you go on maternity leave, you can . . . take a reduced rate for your licensing fees because you're not working . . . However, if you pause your licence, then refills won't be refilled under your name for your patients . . . I'm planning on taking a maternity leave. But I'm concerned about pausing my licence because so many of my patients don't have a family doctor, and that means [they] won't be able to refill their medications. That could cause serious morbidity to patients . . . There's lots of little pieces to this puzzle, where the family doctor crisis has many effects, beyond even what we think about on the surface. And we're all really thinking about the system and our patients a lot. Even with our personal life decisions, like taking your maternity leave, and for how long, and for appropriate coverage, etc.
	Moral distress and injury	I feel that group level of distress increasing from a lack of primary care. None of us want to be closing our wait lists. I think we all would like to be serving the community and meeting the community's needs . . . It's sort of an increasing sense of hopelessness.

outcomes cannot be proven. The participants acknowledged that the family physician shortage was not the only stressor impacting their lives. Finally, a student researcher conducted the interviews. Some participants expressed concern that sharing their experiences could "scare her away" from medicine; as a result, they may have tempered their comments.

Conclusions

This study illustrates the complex interdependencies between family physicians and specialists and provides insight into the unique experiences of physicians who are providing specialist care today. It is clear that the family physician shortage is having far-reaching consequences for patients. Equally clear is that the shortage is also impacting other health care professionals by compounding the capacity strains they were already experiencing. Without sustained attention to both the labor needs and current impacts of health care shortages, the system will continue to operate in a fragmented, suboptimal way, putting patients—and physicians—at continued risk. ■

Competing interests

None declared.

Lack of primary care capacity has been identified as a barrier to implementing care models that could improve the sustainability of the specialist workforce.

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Is food insecurity the issue, or is it discrimination?

Community food security means always having access to a safe, nutritious diet through a sustainable system that promotes healthy choices, self-reliance, and equal access.[1] Food insecurity is "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so."[2] Understanding community food security is essential, because its impacts on health, economics, and social equity are profound and far-reaching.

Food insecurity is about health. Food insecurity is correlated with poor health, functional limitations, and chronic conditions.[3,4] It's linked to childhood asthma, depression, obesity, and academic performance.[4,5] Food-insecure individuals experience higher rates of anxiety, hopelessness, and depression, with limited social support.[4]

Food insecurity is costly. Health care spending is 23% higher for working-age adults with marginal food insecurity, increasing to 121% when food insecurity is severe.[6] In 2011, 12.3% of Canadians were considered food insecure; by 2022, this had increased to 17.8%.[7,8]

Food insecurity is ageist. One in four Canadian children faces food insecurity, with 1.2 million children affected in 2022, impacting lifelong health and economic outcomes.[7]

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.*

Food insecurity is racial. People who identify as Black or Indigenous experience disproportionate rates of food insecurity (39.2% and 33.4%, respectively), compared with those who identify as White (15.3%).[7] Indigenous people are more likely to live in rural areas, with high food costs and challenging transportation networks. Colonization has disrupted both traditional passing down of cultural knowledge and traditional food systems.[9]

Food insecurity is sexist and ableist. Households headed by single women are more likely to be food insecure, and people with disabilities have 3 times higher rates of food insecurity.[10]

Food insecurity is about government policy. BC has the second-lowest provincial rate of food insecurity, after Quebec.[7] BC's minimum wage has increased from $10.25 in 2013 to $16.75 now, contributing to its improved standing among provinces regarding food insecurity.[11]

Food insecurity is about income. Food insecurity rates halve at age 65, when individuals gain access to the Canada Pension Plan and Old Age Security.[7] Access to reliable, adequate funds that are adjusted based on inflation has been proven to decrease food insecurity.

Food insecurity is about climate change. Extreme weather events such as heat waves, heavy rain, and droughts hinder food production. Ironically, global food production contributes to one-third of the world's greenhouse gases and significantly impacts biodiversity loss.[9]

Canadian policies often address food insecurity through food banks, meal programs, and food prescriptions; however, they do not address food security. Policies targeting social determinants provide the largest sustained improvements. Evidence supports a higher minimum wage, a guaranteed basic income, meaningful employment opportunities, and addressing systemic inequities.[13]

Reducing disparities in food insecurity, prejudice, and poverty offers clear benefits. As physicians, we see the impacts on our patients and the health care system. We must advocate for social and climate policies for the long-term health of all. ■

—Selena Lawrie, CCFP
COHP Member

—Jennifer M. Phillips, CCFP
COHP Member

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Continued on page 218

Respiratory virus surveillance after the height of the COVID-19 pandemic

On 11 March 2020, the World Health Organization declared COVID-19 to be a pandemic; 4 years later, we revisit the impacts of the pandemic on provincial viral respiratory illness surveillance, led by the BC Centre for Disease Control (BCCDC) and the BCCDC Public Health Laboratory.

Enhancements to surveillance

Laboratory testing

COVID-19 necessitated changes to viral respiratory monitoring. During the pandemic, both testing and genomic sequencing capacities increased in parallel with changes to testing practices. For example, the current recommendation for each patient sample submitted for viral respiratory illness is to first test for influenza A/B, SARS-CoV-2, and respiratory syncytial virus.[1] Previously, testing may have been limited to only a subset of these viruses. In addition, viral respiratory illness surveillance has been enhanced to include wastewater testing. We currently test wastewater samples for influenza A/B, SARS-CoV-2, and respiratory syncytial virus at 12 sites across the province and will be reporting genomic sequencing of these samples in the future.

Data sources and linkages

Data accessibility and linkages also improved in response to the pandemic. Laboratory data can now be linked to clinical information from administrative data and provincial registries, as well as demographic records in the BC COVID-19 Data Library surveillance platform, a provincially supported proof-of-concept cloud-based system.[2] This system is currently being replaced by the Provincial Health Services Authority Platform for Analytics and Data, which has a broader focus. These environments allow for simplified data governance, a common user interface, and the ability to link multiple data sources, which enhances surveillance and evaluation capacity.

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

The viral respiratory illness surveillance system is nimble, with the goals of providing relevant information to all users and efficiently responding to changing needs.

Dashboards

These comprehensive data are available in near real time and allow for surveillance of multiple indicators. The BCCDC and the BCCDC Public Health Laboratory use these data to provide timely information on viral respiratory illness using wastewater, genomic, and clinical data that is communicated to the public and health partners via a suite of semi-interactive public dashboards with epidemiologic synthesis and interpretation.[3] This work is done in partnership with health authorities; the Data, Analytics, Reporting, and Evaluation team at the Provincial Health Services Authority; and the Ministry of Health.

Evaluation of viral respiratory illness surveillance products is ongoing. The surveillance system is nimble, with the goals of providing relevant information to all users and efficiently responding to changing needs.

Where we are now

Innovative technologies and increased resources made available for the COVID-19 response strengthened our ability to provide timely and comprehensive intelligence to inform public health action for viral respiratory illness. These data provide situational awareness for health care providers to support clinical management, such as signaling the beginning of influenza season to help guide decisions on prescribing presumptive influenza antivirals, and for health care settings, to help inform when enhanced infection control measures should begin. In addition, these data inform vaccination schedules and prioritization.

Respiratory virus activity sometimes settles into familiar seasonal patterns, but genetic changes in circulating viruses can make each respiratory season different and somewhat unpredictable. Prevention strategies such as handwashing, getting vaccinated as recommended, and staying home or wearing a mask when sick mitigate viral spread and remain good advice to reduce the risk of viral transmission and severe illness. We continue to monitor several viral respiratory illnesses, assess them across indicators and various data sources, and validate our interpretations with clinicians and other experts to help inform patient and population care. ■

—Megan Edwards, PhD, MPH
Epidemiologist, BCCDC Public Health Response

Continued on page 218

The WorkSafeBC Critical Incident Response Program: A resource for you and your patients

During the course of their work, people may be exposed to a distressing event, and the impact of the exposure can linger. It could be witnessing violence or death, being threatened, or experiencing a near miss where something terrible could have happened but didn't. Even with experience or strong coping strategies, people may replay an event or struggle with what they saw or heard.

As a physician, you know this can happen to even the most seasoned professionals—including health care professionals—and can result in irritability, difficulty concentrating, or changes in sleep patterns and appetite, among other symptoms. Although people are inherently resilient and usually return to normal functioning in time, for some it can be helpful to get support from a mental health clinician and have their responses to these work-related experiences validated and normalized.

Mental health professionals are available after a critical incident at work

For over 2 decades, WorkSafeBC has offered critical incident interventions to workers and employers across the province after an event experienced in their work. The Critical Incident Response (CIR) Program has an open referral policy, and services are available to any employer or person working in BC and to BC-based workers working temporarily outside the province, even if they may not be a worker under the Workers Compensation Act or if they have not filed a claim. Through the CIR Program, we refer people to mental health professionals across the province to obtain support and psychoeducation, review healthy short-term coping strategies, and be reminded of formal and informal resources. The services are voluntary and confidential, with some limitations.

Over the years, we have developed a network of qualified registered clinical counselors, social workers, and psychologists who come with various lived and professional experiences; we try to pair those who are accessing our services with a mental health professional we believe will match their needs. Our network is responsive, and we are often able to connect people with mental health clinicians within days. Those accessing our services are eligible for an initial session and up to 5 hours of follow-up support. We encourage people to access services soon after a work-related critical incident, usually within 3 weeks. Services are not diagnostic in nature and can be accessed in person or virtually.

The CIR Program is not intended to replace other key supports, including turning to trusted confidants when feeling overwhelmed or using individualized self-care strategies. But for some, the CIR Program can be a helpful short-term support. Anyone who feels the psychological impacts of an incident lingering and thinks they could benefit from longer-term support can file a claim with WorkSafeBC, provided they are a worker under the Workers Compensation Act.

This early-intervention service is available to your patients who may have been exposed to a distressing event in their work, as well as to you. It is not intended for general or cumulative stressors, nor for events that occur outside of work. We recently briefed the Physician Health Program on the services available through the CIR Program.

To get support or learn more

If you have questions, would like to consult or make a referral, or have experienced a critical incident in your work and want support, call our external answering service at 1 888 922-3700. They will connect you with one of our CIR Program team members, all of whom have backgrounds in clinical counseling or social work. The line is open 7 days a week, 9 a.m. to 11 p.m. For more information, see www.worksafebc.com/critical-incident-response. ■

—Amber Sawkins, MSW, RSW
Manager, Incident Response Programs, WorkSafeBC

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

Coming soon:

5th Annual WorkSafeBC–NAOEM Joint Conference for Community Physicians

Join us on Saturday, 26 October, for the WorkSafeBC–Northwest Association of Occupational and Environmental Medicine (NAOEM) joint conference. Attend in person (in Kelowna) or online. In-person attendees can also participate in a worksite visit on 25 October and an educational event that evening.

For more information and to register, visit https://ubccpd.ca and search for "WorkSafeBC-NAOEM."

Continued from page 215

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Continued from page 216

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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 have introduced 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.

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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 Frances Carolyn McGrath

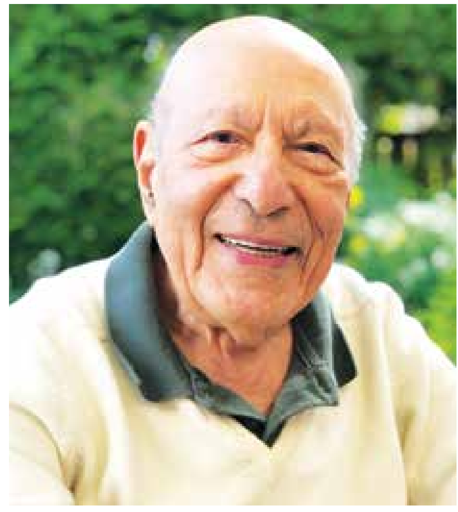
1946–2023

Dr Frances Carolyn McGrath graduated from Eric Hamber Secondary School and attended the University of British Columbia for her undergraduate science degree. She then completed her medical degree at McGill University and subsequently returned to Surrey in 1977 to practise family medicine. At one time, she was the busiest woman physician on Scott Road, handling obstetrics, deliveries, pediatrics, and general medicine. She worked diligently serving her patients for many years. After her retirement in 2017, her general health declined, and she passed away on 18 July 2023, at home in her sleep.

Fran enjoyed attending concerts, shopping, and completing sewing projects in her spare time. She was also active with her support of the Liberal Party of Canada.

As Fran has no immediate family, I hope this obituary will serve as an appreciation of her life, her work and service to her patients, and her kindness to her colleagues and friends.

—Juliet Lau, MBBS
Surrey



Dr Abdel Aziz Ahmed (Aziz) Nazif

1930–2023

Dr Aziz Nazif passed away in Vancouver General Hospital, surrounded and comforted by loving family members, on 5 August 2023.

A gentle man and a gentleman, Aziz was born in Cairo, Egypt, to Ahmed Nazif and Aziza Yehia. His father died at a young age, ultimately creating strong bonds between Aziz and his two brothers, Mohamed and Aly.

Aziz studied medicine at Cairo University, specializing in psychiatry. He took his studies to Montreal at McGill University and the Allan Memorial Institute, where he met his future wife, Joan (Ellefson) Nazif. Disliking the cold, they moved to Vancouver, where Aziz practised psychiatry for almost 50 years. Retiring at the age of 82, Aziz said that his work was one of the greatest joys and accomplishments of his life.

Aziz was a kind, perceptive, tolerant, humble, privately religious, and cerebral man. He loved his grandchildren dearly. He was a lifelong learner, had an infallible memory, and was the family repository of information. He learned languages easily and spoke English, Arabic, French, Spanish, and Italian. In his retirement years, he would retreat to his study to deepen his knowledge on a variety of subjects. Aziz immensely enjoyed the simple pleasures of life, such as hosting his family and friends for dinner, good chocolate, a Turkish coffee, juicy oranges, and mangoes.

Grateful until the end, Aziz expressed many times his good fortune for the full life he had lived. He was a man who gave far more than he took and was a beacon of strength and stability. Predeceased by his older brother, Mohamed, he leaves behind his loving wife, Joan; his daughters, Mona (Peter) and Laila; his son, Omar (Laura); his grandchildren, Nicholas, Sebastian, Benjamin, and Sarah; and his brother, Aly. Aziz will be deeply and dearly missed. Donations in his memory can be made to Eagle Ridge Hospital Foundation (www.erhf.ca) designating Cottonwood Lodge mental health facility as the recipient.

—Omar Nazif, MD, PEng, FRCSC
Vancouver

—Mona Nazif, MBA
Markham, ON

Dr Michael G. Bendall
1946–2024

Dr Michael G. Bendall passed away on 16 January 2024, with his wife Celeste and little dog Coco at his side, while "Adagio for Strings" played in the background. He was at the Wind River Hospice House, surrounded by love. He left us too soon, a result of ALS.

He leaves his wife, Celeste Sundquist-Bendall; son, Charlie Bendall; granddaughter, Hayden Smith Bendall; and stepson, Sam Carson. Family members in South Africa include his nephews, Bradd Bendall and Kevin Bendall; great-nieces, Chelsea and Britney; and great-nephew, Tommy.

Michael was born in Johannesburg, South Africa, to Iris May and Ernest Gordon Bendall. He was predeceased by his parents and his brother, John.

Michael had a passion for the natural world and enjoyed wildlife safaris in Africa, birding, camping, sailing, and boating. It was a delight to walk with Michael and listen to him identify birds by their songs, while pointing out interesting plants and flowers. To Michael, it was all interesting.

Michael was a compassionate, dedicated physician who strived to do his best and improve the lives of his many patients. His efforts improved the obstetric and gynecological care available in the North. A practising physician for 43 years, Michael spent his early years in Iqaluit, Northwest Territories (then known as Frobisher Bay). He traveled by Ski-Doo to make house calls to the Inuit Elders in the communities, and he learned some Inuktitut to better serve his patients. He provided care to the Inuit on Baffin Island and traveled to medical visits in the remote villages in the High Arctic.

In 1980, he filled the position of community-based obstetrician/gynecologist in Whitehorse, Yukon. For 6 years, he was the only specialist providing these services for women and girls, working with the utmost dedication, understanding, and skill. He put the needs of his patients ahead of his personal life.

Michael was available 24 hours a day, every day, in case of an emergency. This meant being within 20 minutes of the Whitehorse General Hospital at all times—day, night, weekends, and holidays. Michael provided this service in addition to looking after the daily routines of surgeries and patient visits to the clinic. Over his career, he delivered many thousands of babies and not infrequently saved the lives of those babies and their mothers.

In the early 1980s, Michael initiated the first ultrasound service in Yukon. With the help of a generous donation from the local rotary club, Whitehorse General Hospital was able to purchase the territory's first ultrasound machine. Michael performed all obstetric and gynecological ultrasounds for several years.

He was also on the board of the Friends of McIntyre Creek, a grassroots volunteer organization with the mandate to attain park status to maintain the integrity of the last linear game corridor in Whitehorse and to permanently protect this gem of a wetland.

Michael supported global relief organizations such as Doctors Without Borders, Operation Smile, and the Canadian Red Cross.

He also enjoyed music and frequently attended the Kluane Mountain Bluegrass Festival, Jazz on the Wing, and many other concerts.

In addition to his medical qualifications, Michael held a degree in horticulture.

His friends will miss engaging with him in thoughtful discussions. No topic was out of bounds, and his quick wit and sparkling humor kept things from getting too heavy. He loved to try to solve the problems of the world!

Michael was a recipient of a Yukon 125 commemorative medal, awarded in recognition of his professional and community contributions. His work and leadership helped make a better place for all Yukoners. He will be remembered for his sacrifice and commitment to his community and to Canadians as a whole. His absence will be felt by many for years to come.

Thank you to Drs Jamie Wilkie, Alex Kmet, Alex Coholen, and Sally Macdonald. A special thank you to the outstanding staff at the hospice, who cared for him in his last days with the utmost professionalism, sensitivity, and kindness. We feel truly privileged to have received such high-quality care.

At Michael's request, there will be no service or celebration of life.

—Celeste Sundquist-Bendall
Whitehorse, YT

Correction: Recently deceased physicians

The list of recently deceased physicians published in the May issue of the *BCMJ* (2024;66:135-136) incorrectly included Dr Shane Albert Longman. Dr Longman is not deceased. We apologize to Dr Longman for this error and to the family members of deceased Doctors of BC members if there are any other errors on the list.

Classifieds

Pricing (two options): Run an online-only ad at our monthly online rates, or pay an additional $25 per month for an ad to appear in print as well. **Online rates:** Doctors of BC members: $50 + GST per month per ad of up to 350 characters. $75 + GST for 351 to 700 characters. Nonmembers: $60 + GST per month per ad of up to 350 characters. $90 + GST for 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.

Place a classified ad: bcmj.org/classified-advertising. Payment is required at the time that you place the ad.

New classified advertising categories: The new Events section can be used for CME or other events, and the Vacation Properties section has been renamed Accommodation. The same rates apply.

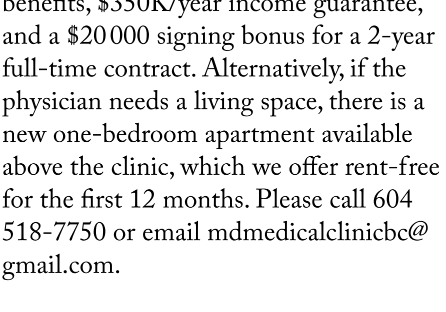
EMPLOYMENT

COQUITLAM—SPECIALISTS, LOCUMS, FPS
Bonne Vie Medical is situated in a newly renovated 2500 sq. ft. clinic in an outside-facing unit at Coquitlam's busiest mall. We are welcoming family physicians, specialists, and other health professionals interested in full-time, part-time, locum, in-clinic, and/or telemedicine care. The clinic's multidisciplinary approach offers primary care, medical aesthetics, mental health, travel medicine, and state-of-the-art lasers and treatment technologies under one roof. Digital health innovations are developed here, providing staff with complimentary access to select innovations and services. For more details, please call 604 900-8028, email hello@bonneviemedical.com, or visit www.bonneviemedical.com.

DUNCAN—COWICHAN DISTRICT HOSPITAL—FP ONCOLOGIST
We have full-time and part-time opportunities to join the current team of two FP oncologists who are overseeing chemotherapy for cancer patients in the Cowichan District. The main role of these positions is managing patients on active cancer treatment. No oncology experience is necessary. Training is available through the Family Practice Oncology Network. Start date: as soon as possible. Benefits: may be eligible for additional remuneration in accordance with the Rural Practice Subsidiary Agreement (https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/physician-compensation/rural-practice-programs). Facility: Cowichan District Hospital in Duncan. Remuneration: service contract. Contact Savanah Munzar at Savanah.Munzar@islandhealth.ca.

MAYNE ISLAND—SOUTHERN GULF ISLANDS—FP
Unique opportunity: family practice clinic, fully equipped, providing primary care and urgent and emergent episodic care (population 1320) seeks an additional family physician. Work-life balance, beautiful scenic island, 1.5-hour ferry to Victoria or Vancouver. Attractive and flexible Alternative Payments Program contract with Island Health with additional relocation and rural retention benefits, 38 paid locum days, and MOCAP renumeration (on call 1 day/week and 1 weekend/month). Posting: https://mayneislandhealth.ca, https://medicalstaff.islandhealth.ca/node/6723. CCFP and eligibility for full Canadian licence with the CPSBC mandatory. For more details contact admin@mihcaboard.ca or call Dr Losier at 250 539-2312.

PORT COQUITLAM—FP FULL-TIME OR PART-TIME
MD Medical Clinic is looking for a full-time or part-time family physician. There are currently more than 2700 patients on a wait list. The clinic uses Oscar EMR and offers billing support. Split arrangement is 80/20. Potential annual earnings are $400 000 to $600 000. Overhead includes everything, such as MOA, EMR, and equipment. Incentives include dental/medical extended health benefits, $350K/year income guarantee, and a $20 000 signing bonus for a 2-year full-time contract. Alternatively, if the physician needs a living space, there is a new one-bedroom apartment available above the clinic, which we offer rent-free for the first 12 months. Please call 604 518-7750 or email mdmedicalclinicbc@gmail.com.



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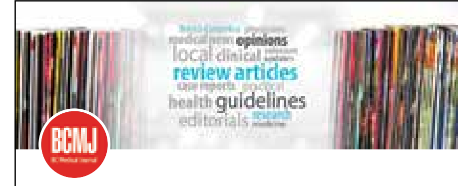

BC to fund #IVF: For whom and how? BC is in a unique position to learn from other provinces and countries that offer #fertility funding. We review the available data and consider how to provide equitable access for BC residents.

Read the article: bcmj.org/articles/bc-fund-vitro-fertilization-whom-and-how

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VICTORIA, BURNABY, LANGLEY—SLEEP MEDICINE
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EVENTS

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Find more classified ads online: bcmj.org/classifieds.

CME Calendar: Discontinued

To place a CME ad, use the Events section in the classified listings (same rates apply).

NEW CONTENT TYPE:

Clinical Images

Have you seen an interesting clinical image lately? Share it with colleagues by submitting it to the *BCMJ* for publication. We have introduced a new type of *BCMJ* content: Clinical Images. Submit an image with case description or image description (200–300 words) and a maximum of five references. Images must be high resolution and include a patient consent form.

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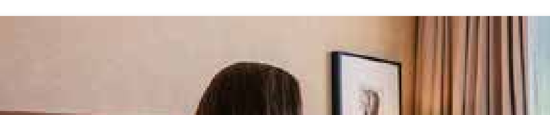

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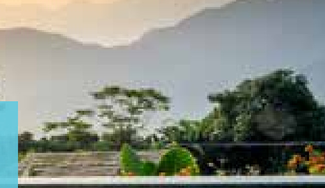

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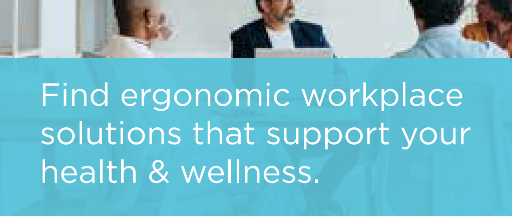

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