

I miss the CPSBC Library

One year ago, on 15 March 2024, the College of Physicians and Surgeons of BC (CPSBC) decided to close our medical library. In response, I wrote an editorial expressing my disappointment.¹ As you may recall, this closure was made without consulting registrants and with minimal notice to physicians and staff.

The *BCMJ* received a record number of letters in response—more than on any other topic in recent memory. Dr Koehler wrote that although information on the Internet is easily accessible, it can be inadequate and biased. Dr Koehler hoped the CPSBC would recognize its members' need for accurate information.² Dr Kope pointed out that the CPSBC's rationale to close the Library due to a "significant decrease in library use" stands in contrast to important principles for health promotion in medicine despite declining uptake, such as the case of immunizations.³ Many physicians shared that they relied on the Library to tackle complex clinical questions and valued the monthly *Cites & Bytes* newsletter. Additionally, I received numerous private messages, emails, and other personal communications from physicians who expressed that the CPSBC Library was an invaluable resource.

On a personal note, the closure of the Library has significantly impacted my research mentorship for medical students and residents. I depended on the Library's support for literature searches and reviews, which helped students refine their research questions and improve their study design. Moreover, in preparing my annual lectures for University of British Columbia undergraduate classes, the CPSBC Library team made it far easier to stay current on new publications related to my topics. Without their assistance, this task has become far more time-consuming.

Dr Gillespie suggested a possible "win-win solution": that Doctors of BC take

over the medical library.⁴ This suggestion received several notes of support. However, given the current economic climate, this option seems unlikely in the near term.

For perspective, I calculated that in 2023, we paid approximately \$125.54 annually per active registrant for access to library services, which is comparatively smaller than the \$25 paid in 1963, considering inflation.¹ Recently, I reached out to the CPSBC again to ask if it might be open to discussing the Library's closure with the *BCMJ*—particularly whether there were any plans to consult registrants about potentially reopening the Library or reallocating the Library's budget. According to the CPSBC's 2024–2028 strategic plan, there is an emphasis on transparency, particularly in "provid[ing] clear, relevant, and timely information about [its] mandate and work."⁵ This seems relevant, as many have asked how the Library's \$1.86 million budget will be redirected. The CPSBC communications team responded to me: "While we understand that the decision to close the library is disappointing to some registrants, CPSBC will not reconsider it. It is the role of the CPSBC Board to determine strategic and financial priorities. The decision to close the library was made by the board after careful consideration showing significant decrease in use over the years."

If the closure is indeed the result of necessary budget cuts—an unfortunate but perhaps inevitable reality—we may need to accept that this is the cost of doing business in today's inflationary times. There's no denying the utility of digital platforms such as UpToDate, which provide immediate access to clinical information. For those of us with academic or health authority affiliations, we may still have access to resources through hospital librarians or UBC. But many of us relied entirely on the CPSBC Library for access to journals, books, point-of-care tools, pharmacopeia,

drug interaction checkers, reading lists, videos, and more. According to the CPSBC's committee reports for the 3 years prior to the closure, an average of 1710 physicians submitted over 10 000 queries, and roughly 46 500 articles were downloaded through the CPSBC Library website. If you were one of those physicians, what do you do now?

In our Letters to the Editor in this issue, Rachael Bradshaw, Melissa Caines, and Jane Jun write on behalf of the Health Libraries Association of BC's executive board to share their thoughts on the enduring value of librarians.⁶ Out of respect and gratitude for the former CPSBC Library team, we're publishing this letter despite the uncertain prognosis for this cause. When we look back on this moment—5, 10, or 25 years from now—perhaps we will regard this period as a sign of the times. Free and reliable forms of artificial intelligence may have stepped into the gap left by the Library. Yet, I suspect that the transition will not be as swift or seamless as some anticipate. For now, patients rely on our expertise, and in turn we rely on the resources that help us provide the best care possible. Libraries remain essential to that mission. ■

—Caitlin Dunne, MD, FRCSC

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I, Robot

Island Health robot has finally arrived. However, this is not a science fiction movie set in 2035, the producers and cast do not include Will Smith, and the robot is not automated and human-like. This is a Canadian reality show from 2025 set in Victoria, BC. The producers and cast include ordinary, kind-hearted individuals with one common goal: enhancing patient care through surgical innovation.

Thanks to generous community donors to the Victoria Hospitals Foundation, as part of the newly launched campaign “It’s Time for Surgical Innovation,” Vancouver Island patients can now benefit from robotic surgery in Victoria. The Island Health robot is called the da Vinci Surgical System, and it does not look like nor is it meant to replace humans.

Robotic surgery has been around for many years and is currently considered the standard of care in the United States. Initially used mainly in urology, it is now used in various other surgical disciplines as well, such as general surgery; ear, nose, and throat; and gynecology. It offers many benefits to both surgeons and patients.

For surgeons, robotic surgery provides improved ergonomics with less physical demand, allowing surgeons to remain in a tailored sitting position during long operations. It also provides better visualization and depth perception with 3D imaging and a surgeon-operated camera. These characteristics can result in reduced musculoskeletal and mental fatigue, improved performance, and fewer errors.¹ With additional freedom and dexterity, while eliminating tremors and increasing magnification to scale movements, robotic surgery allows for more efficient and more accurate surgery.

From a patient’s perspective, minimally invasive surgery has been long established to result in improved patient outcomes, and robotic surgery allows a greater proportion

of operations to be completed in a minimally invasive fashion.²

Clinical benefits of robotic surgery are well known in the field of urology. In other disciplines, such as general surgery, the evidence is evolving, but at the very least, we know robotic surgery is noninferior and, in some instances, superior to laparoscopic surgery. In colorectal surgery, specifically rectal resection, lower rates of conversion to open surgery is a widely accepted benefit of robotic surgery.³ This is especially the case in obese patients, where access to a deep, narrow pelvis can be challenging laparoscopically. Conversion to open surgery can have a significant impact on patient outcomes, such as increased wound complications, anastomotic leak, and overall morbidity.⁴ Recent meta-analyses and systematic reviews have demonstrated that robotic surgery, compared with laparoscopic surgery, resulted in significantly faster bowel recovery, shorter length of hospital stay, and lower overall complication rates.^{5,6} Urinary and sexual dysfunction have also been shown to be reduced in robotic rectal surgery compared with a laparoscopic approach.⁷

Despite the benefits of robotic surgery, its adoption in Canada has been slow, primarily due to cost. The purchase price of a robot is \$2–3 million, with additional costs of around \$3500 per case and \$180000 in annual maintenance. In a publicly funded health care system, justifying the additional cost may be considered prohibitive by some, and predictably, the majority of robotic systems are purchased through philanthropic donations to hospital foundations. However, the cost of surgery extends beyond the operating rooms, and the many benefits of robotic surgery may result in reduced overall costs. In a retrospective study from Kingston, Ontario, Patel and colleagues demonstrated that implementing a robotic colorectal surgery program in a Canadian tertiary care centre did not significantly increase the cost of care.⁸

Additionally, access and cost-effectiveness are expected to improve as more competitors enter the robotics market. Last, studies comparing robotic surgery with laparoscopic surgery have indicated increased operative time as a downside (an additional 20 to 30 minutes in rectal surgery);⁵ however, this will become a nonissue as surgeons become more efficient at docking and using the system.

To use robotic surgery in practice, it must be incorporated into surgical training. In a survey of program directors from Canadian general surgery residency and fellowship programs, less than 5% of resident clinical case volume constituted robotic surgery. More importantly, none of the program directors felt their trainees would be competent in using the robot after training. The good news is that skills acquired during laparoscopic surgery are translatable to robotic surgery, with a shorter learning curve.⁹ With more robotic systems entering the market, lower costs, and increased accessibility, combined with dedicated robotic training programs in surgical residency, the uptake of robotic surgery in Canada should hopefully pick up the pace.

As for what comes next, the introduction of artificial intelligence and automation in robots could be used to guide and assess surgeons in performing surgeries more efficiently and effectively, which leads to the question: How far could or should this be taken? Could an automated robot using artificial intelligence turn on its creator? Stay tuned. ■

—Sepehr Khorasani, MD, MSc, FRCSC

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is that when managers or staff show interest in this option, they often move on to other positions. It is difficult to elevate this issue to a level where an executive will take responsibility and introduce the screening at all our clinics.

There are added difficulties in helping people who have no address or email access and are disabled to the extent that they cannot reliably take part or follow up unless they are helped to do so. I hope someone reading this letter will take notice and persuade health authority support services to, as the movie says, “do the right thing.”

—Ralph Jones, MD
Chilliwack

Re: Supporting the stillbirth journey at BC Women’s Hospital and Health Centre

We are writing in response to the article by Gill and colleagues¹ on supporting bereaved parents who have experienced stillbirth. We were impressed with the care taken to involve those with personal experience in research to inform improved care. However, it was noticeable that the article avoided using terms such as “women,” “mothers,” “men,” and “fathers” that would make the sex of the people involved clear. This avoidance of referencing sex (desexed language) when sex is important has increasingly occurred as the cultural salience of the concept of gender identity has risen, but it presents a variety of difficulties,^{2,3} and this article is no exception.

When a stillbirth occurs, both mothers and fathers can be said to have experienced the stillbirth of their child, but they have not had the same experience. A pregnant woman whose fetus dies late in pregnancy or during birth and gives birth to a dead baby does not have the same experience as a father who observes this process, even though he also grieves. However, this article makes it difficult or impossible to determine whose experience is being described. In summarizing the research, “people” is used to refer to mothers only; to mothers and fathers; and to mothers, fathers, and extended family. One has to read each

reference to know. Similarly, it is sometimes difficult or impossible to distinguish whether the study findings refer to mothers, fathers, or both. The same is the case with quotations.

The article notes there is sensitivity around language in relation to stillbirth and explains that the term “bereaved parents” is used “to reflect the preferred language of our study participants.” However, this does not appear to clearly be the case. One study participant is quoted as saying she would have “appreciated being treated like a *mom*. . . . It would have helped me to have felt cared for and treated like a *mom*” (emphasis added). And the words of another study participant were altered, perhaps to avoid “women” or “mothers”: “[There is a need to] create a network of [*parents*] who have been through it” (emphasis added). Further, fathers are sometimes referred to as “partners,” and in this way their relationship to their child is marginalized. This is even in a sentence noting their marginalization: “Partners often face the erasure of their status as grieving parents.”

The potential for causing distress by not recognizing the different stillbirth experiences of women and men and not accounting for this in the care provided to them and the language used needs to be appreciated. The second author of this letter has extensive experience providing peer support to women who have experienced stillbirth (including in Canada) and emphasizes the importance that many women place on being referred to as mothers.

Of course, we understand the authors’ intent to ensure language is sensitive to the needs of individuals who prefer their sex not be referred to due to their personal experience of gender identity. We agree there should be sensitivity to individual patient language preferences⁴ even while recognizing their sexed experiences.

—Karleen Gribble
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—Ciara Curran
Little Heartbeats

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