Letters to the editor

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From community to hospital: How Burnaby is tackling the substance use and mental health crisis in BC

In 2016, the BC provincial health officer declared a public health emergency due to an increase in drug-related overdoses and deaths. In response, several initiatives were created to minimize the risks associated with substance use.[1,2] We outline three lessons learned during the development and implementation of two projects, one spearheaded by Burnaby Hospital and the other by the Burnaby Division of Family Practice in collaboration with the Shared Care Committee, a Joint Collaborative Committee of Doctors of BC and the BC government.

Lesson 1: There was a gap in knowledge about substance use care and resources among Burnaby Hospital staff, community providers, and the public

Burnaby Hospital's Addiction Medicine Consult Team initiated a series of quality improvement projects in 2022. The team surveyed 22 physicians and 36 allied health professionals and nurses about substance use care. Overall, 42% disagreed or strongly disagreed with the statement "I have proficient knowledge on addiction medicine resources relevant to the Fraser Health region."

The Burnaby Division of Family Practice and the Shared Care Committee surveyed the Burnaby public on substance use and mental health in 2022: 181 of 340 respondents (53.2%) agreed and 29 (8.5%) strongly agreed with the statement "I know where to get help for substance use challenges that may affect me or someone else in Burnaby." Of 51 Burnaby clinicians who were also surveyed, 19 (37.3%) agreed and 4 (7.8%) strongly agreed with the statement "I am aware of substance use supports and resources that I can refer my patients/clients [to] within Burnaby."

Lesson 2: It's not a lack of resources; it's a lack of pathways to find them

Project teams suspected that knowledge accessibility was a primary factor in the knowledge disparity in the hospital and the community. In response, two tools were created to better direct evidence-based guidelines and patient information through health authorities and provide clinicians with tools to address knowledge gaps and reduce the impact of siloed resources:

- Burnaby Hospital's Addiction Medicine Consult Team created the Burnaby Resources on Substance Use website (www.brsu.ca), a central repository of addiction care resources, in 2022. The website was evaluated by 37 hospital staff between 2022 and 2023, and 30 providers (81%) reported learning about four or more resources after using the website for a minimum of 5 minutes.
- The Shared Care team developed the Burnaby Community Resource Directory (https://burnabypcn.ca/social-supports/) to allow Burnaby residents to navigate their local services with ease.

Lesson 3: Interdisciplinary collaboration is critical to improve substance use and mental health challenges

Creating community-minded solutions that meet the diverse needs of patients with complex social and medical challenges requires perspectives from all levels of care. The success of the initiatives discussed here stems from collaborative efforts among quality improvement experts, diverse clinicians, and experienced community health care workers and highlights the value of collaborative care and input. Given the complexity of addiction care, creating connections across disciplines allows for a broader understanding of the health care community and the implementation of more holistic solutions for patients. Additionally, working collaboratively on unified goals allows for shared knowledge and the opportunity to create innovative solutions.

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The Invictus Games: Reflections from a medical volunteer

The Invictus Games Vancouver Whistler 2025 concluded on 16 February 2025. It is the seventh time the Invictus Games have been held and the first time they have included winter sports. The games are a multisport event for wounded, injured, or sick (WIS) military veterans from Canada and its allies, attracting over 500 competitors from 23 nations. The term *WIS* is used by the Invictus Games Foundation.

The event would not have been possible without volunteers, and, as with all major sporting events, there was a well-organized medical team with outstanding leadership and excellent pregame training. It was an honor for me to work with all the physicians, surgeons, physiotherapists, registered massage therapists, nurses, chiropractors, and pharmacists. The dedication of the medical volunteers was exceptional; some had traveled at their own expense from other provinces and from overseas. Their motivation was obvious: to show appreciation to those who knowingly placed themselves in harm's way to defend the democratic freedoms we benefit from and had suffered as a result. My motivation originated after a visit to Omaha Beach and Juno Beach, two sites of the D-Day landings in Normandy, France, on 6 June 1944.

As part of our uniforms, we were provided distinctive yellow coats that identified us as being with the games. When I was coming home on the SkyTrain late one night after a shift, a well-dressed, articulate young man attempted to engage me in debate. He stated that Canadians did not believe in war and should not support efforts to promote war. He was persistent, although I did not feel threatened and chose not to respond. The encounter made me sad more than anything else, as I suspect that soldiers despise the effects of war, just as health care providers hate disease. As health care workers, we treat the sick and injured; that is our mission. Similarly, military folks also have a mission, only carrying out *their* duties may result in their own disability or death.

With it being the 80th anniversary of the end of World War II this year, it is time to be appreciative for the society we have the privilege to live in. Had the Axis powers won that war, the young man would not have been allowed to voice his opinions in public. To all our veterans, past and present, thank you for your service.

—Eric M. Yoshida, OBC, MD, FRCPC
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Re: Doctors need electronic health records to work for us, not the other way around

Kudos to Drs Tseng and Lee for their informative and important letter on health care system digitization using the Cerner electronic health record (EHR) system.[1] The points raised in the letter, including shifting administrative tasks to physicians, increasing physician workload, and EHR impacts on patients and physicians, are timely and important. We share the authors' frustrations, and others have reported similar experiences.[2-4]

Many of us with previous experience using other EHR systems have been disappointed with Cerner for some of the reasons raised in the letter, including complex workflows, incomplete data linkages, and increasing workload. We recognize that similar problems exist with other EHR systems. However, more testing and tailoring could potentially have been done before the implementation of Cerner to enhance its effectiveness. As Cerner is a program with some separate components, such as front-end speech recognition and data linkages to other provincial databases, it is likely possible to modify its components individually to make the program function more effectively. This could be tested against other EHR systems. Presumably, incorporating artificial intelligence tools (for example, voice commands and dictating notes) could simplify Cerner. Additionally, Cerner's confusing function-related icons add to the cognitive workload and frustration. It would be helpful for Cerner to study and improve the user experience. This likely has consequences for patient care and patient safety. Organizations implementing EHRs should construct a framework for users to express frustrations and offer suggestions for improvement.

This topic is important to health care in British Columbia and requires much more extensive evaluation and attempts at modification for improvement. It is suitable for an article or an issue of the *BCMJ*, not just a Letter to the Editor

—Charles Krieger, MD, PhD, FRCPC
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—Helen Monkman, PhD
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Re: Rural privileging

I am writing in response to the article on privileging and credentialing through a rural lens [*BCMJ* 2024;66:334-339]. I am a retired rural physician, having worked in family practice in Quesnel for 40 years and then assisting in the operating room for another 17 years before retiring at age 85. After coming to Canada following 3 years doing house jobs in Brighton, UK, I was lucky to do a 1-year anesthesia residency in Vancouver before moving to Quesnel.

In 1965, there was no BC Ambulance Service. The local ambulance, a museum piece from the 1950s, was owned and operated by the local taxi driver. Doctors were sometimes asked to join when they were attending accidents. Additionally, there was no air ambulance, so it was either a military plane from Comox or a plane from West

Fraser, a local sawmill. It was with these constraints that we rural doctors needed to work. A selection of cases might cast insight on privileges.

One February morning in the 1970s, a young man was brought in by the BC Ambulance Service, having been found in a snowdrift, where he had spent the night on his way home from the bar. It had been –20°C overnight. He was unconscious, with a rectal temperature of 29°C. Such cases require careful warming with hot air so the cold periphery does not flood in, reducing the core temperature and causing cardiac arrest. Our best option was a hot bath and to watch for cardiac arrest. His hands were terrible—solid blocks of ice—leaving me with images of eventual amputation through the wrists. In my mind, regular stellate ganglion blocks might salvage some of the tissue. Several days of these were done on the then-conscious patient. I was rewarded with fingers enveloped by brown blisters—all of them. I did not see them after that, but I was told that pink fingers eventually emerged. How would that fit into the suggested version of privileges?

Another case was a 40-year-old woman with Guillain-Barré syndrome who needed 10 days of ventilation. We successfully managed without an ICU, and she is now in her 80s.

On another February morning in the 1970s, as mentioned in a book he wrote, my partner, Dr Alex Holley, asked me to accompany him to Vancouver with a patient we had been caring for with suspicion of a ruptured arch of the aorta following a car accident. Alex had phoned around for air transport. There was poor weather in Comox, but West Fraser brought its small plane from Williams Lake. We went with the patient to Vancouver, along with blood, intubation, and ventilation if needed, through a bumpy descent to the airport due to stormy weather. Two weeks later, the patient came in to the office to thank us and boast of his new aortic arch.

About that time, we had a man who had fallen and broken his neck at C1. Another of my partners happened to be with him at the time. He did resuscitation, and I later put skull tongs on and ventilated him. I accompanied him to Vancouver in the Royal Canadian Air Force's Buffalo from Comox—but at no higher than 5000 feet as we came down the Fraser Canyon, because the plane was not pressurized. With ventilation and traction, the physical challenges could be interesting. Unfortunately, the patient died a few days later.

One more case. One quiet Saturday afternoon in the emergency department, a worried-looking older man with a clearly rustic lifestyle came in and said, "I wonder if you can help me. There's no vet in town and I have a dog with porcupine quills."

"Okay, things are quiet now," I replied. His dogs were cougar hunters! This was a 70-pound, shaggy, fierce-looking hound with a face, mouth, and head patched with barbed quills. Anesthesia would seem to be indicated, but my training had not covered dog anesthesia. I had heard that ventricular fibrillation could be a problem. After some thought, I bypassed the need for IV and inserted two pediatric pentobarbital suppositories. This was followed by some patience and a third insertion, after which sedation ensued, and the quill extraction began with pliers. With the face and head cleared, we turned our attention to the mouth, tongue, and inner cheeks, all the while wondering when the anesthesia would wear off. The treatment was concluded with the dog recovering. The owner was so happy that he said, "I have another one in the car." He was given some suppositories, declined the rubber glove that was offered to him, and left happy. Rural medicine!

—John Maile, MD
Quesnel

Artificial intelligence technology for cervical cancer screening

The article "Cervical screening in BC—Change inspired by First Nations and Métis communities" [*BCMJ* 2024;66:370-374] was very informative in demonstrating that by including care, compassion, and understanding in screening for cervical cancer in this population, the incidence of this preventable disease may be reduced significantly. Hopefully, like in other populations, aided by high acceptance of the human papillomavirus vaccine, cervical cancer will be eradicated in the future.

Another approach can also be used to help individuals who live in remote areas. The use of artificial intelligence technology is being introduced into colposcopic imaging. NTL Healthcare, based in Korea, has developed CerviCARE AI, a handheld device used to diagnose cervical dysplasia with over 95% sensitivity and specificity.[1] For those not familiar with colposcopy statistics, that rate is higher than what a trained colposcopist could achieve. Notably, the device does not require Wi-Fi, as its reference data is within it.

I volunteer with Project HANDS Society, a Canadian registered charitable organization, and since 2013, we have screened over 10 000 women in Bolivia, Myanmar, and Myanmar refugee camps in Thailand using visual inspection with acetic acid. Last November, we used the CerviCARE AI device in the Mae La refugee camp in Thailand for the first time. Not only did we find it accurate by our own visual assessments, but it was also an excellent teaching tool for nurses, midwives, and doctors.

This device, and possibly others that may follow, would be an excellent addition for screening in remote areas. It could significantly reduce the number of patients who would require transportation to a larger centre for colposcopic assessment. Screenings could take place in patients' own communities. This device is already in use in South Asia and Southeast Asia, in countries such as Vietnam, Thailand, Malaysia, Bangladesh, and India.

And a disclaimer: I have no financial interest in this company or the device, and I was a colposcopist prior to retiring.

—Gary C. Jackson, MD
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