Letters to the editor

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Striving for a sustainable, low-carbon health care system

In her October 2022 President's Comment,[1] Dr Ramneek Dosanjh noted, "As physicians, we are all leaders and trusted advocates for our patients and our communities. Now is the time to use this leadership to communicate about the health impacts of climate change, to contribute to short- and long-term strategies that reduce potential harms, and to actively make changes in the health care system for the good of our patients and our planet." I am writing to request that the *BCMJ* further its current impressive leadership[1-6] by including health care sustainability in publication decisions.

Collective recognition of and action on health care's contribution to 4% of national greenhouse gas emissions[7] and pollution can complement and enhance providing low-carbon, high-quality health care,[8] shifting us out of our unenviable position—second-highest per capita in national health care emissions.[9] The *BCMJ* has an opportunity to raise awareness by making it policy to consider emissions and pollution-related concerns in its articles. A commentary in *Lancet Planetary Health* provides eight dimensions that could be adapted for this aim.[10] Centring sustainability for authors and readers may lead to them sharing ideas with patients, who have been shown to support Canadian health systems moving to low-carbon/low-waste care.[4]

Here are two examples of how health care sustainability considerations could have been incorporated into recent articles published in the *BCMJ*:

- "A call to action: Dermatology's role in combatting colorism".[11] If the author had been requested to include sustainability considerations, they would have discovered that many skin-lightening products contain mercury,[12] and a 2022 systematic review demonstrated elevated mercury levels in the urine and blood of skin-lightening product users.[13] This could have been described as a clinical and pollution-related consideration.
- "Implementation of human papillomavirus primary screening for cervical cancer in BC".[14] Significantly reduced use of single-use plastic specula and quicker detection of cancerous and precancerous conditions would have sustainability co-benefits (less intensive health care with fewer emissions and less waste).[15]

Some researchers are already thinking about such considerations. For example, Dr Davie Wong, author of "The unsubstantiated preference for outpatient IV antibiotics," noted that oral antibiotics have a lower carbon footprint than their IV counterparts.[16] The article is about the clinical benefits of oral antibiotics over IV, but it incorporates the environmental co-benefit as well.[17]

In his mandate letter[18] to Minister of Health Josie Osborne, Premier David Eby wrote, "Our commitment to take action on climate change remains foundational and will be key to a healthy and prosperous BC for future generations." Health authorities have a government-mandated commitment to reduce carbon emissions;[19] therefore, sustainable practices must be embedded in our work. The *BCMJ* can support this sustainable, low-carbon health care system by identifying environmental sustainability alongside clinical excellence.

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Editor's note: Thank you for bringing this up. We will consider how to do this.

Re: Closure of the CPSBC Library

I have several provincial licences and have worked in many provinces. I have long admired BC for its progressive steps in ensuring excellence in medical care, one of which was the College of Physicians and Surgeons of BC's Library. I used it frequently. There was and still is nothing else like it, and the librarians were incredibly helpful. Its sudden cessation was a huge loss to physicians who want to research answers to clinical questions to stay current and provide better care and a huge step backward for BC health care. I would have happily paid more to keep it going, but per usual with administrative decisions from above, we physicians weren't asked. Perhaps, in the future, if national licensure ever comes about, a similar resource can be part of the benefits that would provide. We physicians should ask for this.

—Faye MacKay, MD, CCFP, FCFP
Langham, SK

Re: Unnecessary dental antibiotic prescribing

The BCCDC article about how to choose wisely when deciding whether to prescribe prophylactic antibiotics prior to dental procedures [*BCMJ* 2025;67:71-72] left me with a personal quandary: Should I continue my habit of taking a single dose of 2 grams of amoxicillin prior to dental procedures?

According to the article, one does not use prophylactic antibiotics in patients with nonvalvular cardiac or other indwelling devices (such as my pacemaker), only if there is a history of a prosthetic heart valve, a history of infectious endocarditis, cardiac transplant with valvular regurgitation, or certain congenital heart disease scenarios.

A decade ago, I had abdominal surgery, which left me with drains for several months. Six weeks postoperatively, symptoms of septicemia developed. Wound cultures were negative, while blood culture grew *Staphylococcus aureus*. No primary source for this bacterium could be identified. Eight weeks of IV cloxacillin later, symptoms returned within 24 hours of its cessation.

Positron emission tomography scan for endocarditis was negative, so another 8 weeks of IV cloxacillin was tried, only to be followed by recurrent septicemia symptoms for a third time, when antibiotics were stopped.

Pacemaker and leads were then removed. They grew the *Staphylococcus aureus*. Finally, after close to 6 months of antibiotics (and negative blood cultures), a new pacemaker and leads were inserted. No bacteremia recurred.

Acute pericarditis developed 8 weeks postinsertion of the new pacemaker and leads. This inflammation started 24 hours after a routine influenza vaccination. It was felt to be unrelated to the bacteremia and responded to anti-inflammatory treatment.

I would be interested to hear what Dr Patrick and his team would do for themselves before dentistry if they had personally undergone this scenario.

—Anthony Walter, MB BCh, retired
Coldstream

Authors reply

We thank Dr Walter for sharing his story and question in the context of our article. We are pleased to hear that he has been well since clearing the infection he described.

Quoted guidelines like those produced by the American Heart Association serve to distill the best available evidence to inform practice in most cases for most patients. There is always room for variation in unique circumstances upon discussion between physician and patient.

We can offer a few points that might inform that ongoing choice:

- Recurrent problems with *Staphylococcus aureus* bacteremia followed a complicated abdominal surgery, where an infected pacemaker was eventually found to be the reservoir. Endocarditis was a legitimate concern but was not confirmed by investigations. If there

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is anything to suggest past bacterial endocarditis, prophylaxis is still recommended.

- *S. aureus* is the most common cause of infections of various prostheses, including pacemakers, but it is not a major element of the mouth flora, nor a common agent of transient bacteremia with dental manipulation. In the case of an open abdominal wound with prolonged drainage, the wound is much more likely than an oral source to be the portal of entry.
- If the main concern is about reseeding a pacemaker with *S. aureus*, amoxicillin would not be expected to do very much, because most *S. aureus* is generally resistant to it.

We thank Dr Walter for the question and wish him excellent health!

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more than ever, we must stand together to strengthen our community, embrace new opportunities, and continue to advocate for the profession. As we mark this milestone, let's recommit to each other and our profession so we can build an even stronger health care system for future generations.

To all our physicians—past, present, and future—thank you for being part of this journey and, even more, for your unwavering commitment. Here's to the next 125 years of making a difference, one patient at a time. ■

—Charlene Lui, MD
Doctors of BC President

Images included on the cover, from left to right:

- Dr Steve Hardwicke with petitions signed by British Columbians protesting the government's actions to impose budget caps and limit doctors' bargaining rights, 1992.
- Academy of Medicine building, home of the BC Medical Association (BCMA) until 1985. Photo courtesy of the College of Physicians and Surgeons of BC.
- BCMA staff member Ms Tanyss Noftle with returned Medical Services Plan Payment Schedules, 1981.
- Members of the BCMA, 1906.
- Dr Ethlyn Trapp, the first female president of the BCMA, 1946.
- Drs Bill Jory and Bill Ibbott present Minister of Health Bob McClelland with a BCMA "Buckle Up & Live" bumper sticker, 1977.
- Indigenous artist sɬə́məxʷ (Rain Pierre) with his artwork, created as a beacon of safety for Indigenous patients and a symbol of culturally safe care that doctors can display in their offices, 2022.