Letters to the editor

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BC medical trainees' perspectives on Canadian health system improvement

In the face of increasing demands on Canada's health care system, medical trainees across British Columbia are voicing urgent and practical concerns about the future of care delivery.

In February 2024, Prime Minister Justin Trudeau and Minister of Health Adrian Dix gave health care policy speeches at the annual Vancouver Medical Association Osler Dinner. To help give medical trainees a voice at the health care policy decision-making table, we invited UBC medical students and resident physicians to submit questions and policy priorities that they would like presented to Prime Minister Trudeau and Minister Dix at the Osler Dinner. The key principles and priorities of the 61 medical students and 19 residents who responded are shared in this letter.

Federal concerns: Improve health care accessibility, technology, transparency, and physician support

Foremost among medical trainees' federal-level concerns was health care accessibility, with an emphasis on reducing wait times for specialist consultations, emergency care, and surgical procedures. Trainees also highlighted the importance of improving access in rural, remote, and underserved communities, especially in the context of mental health services for youth and marginalized populations.

Trainees called for national strategies to better prepare for future pandemics, strengthen health care infrastructure, and guide the ethical integration of emerging technologies such as artificial intelligence into clinical care. Concerns were raised about transparency and accountability in health care spending, along with calls for

In February 2024, UBC medical students and resident physicians had an opportunity to submit questions and policy priorities at the Vancouver Medical Association Osler Dinner. From left to right: Dr Lee Treanor (radiology), Dr Joban Bal (family medicine), Prime Minister Justin Trudeau, Dr Philip Edgcumbe (radiology), Ms Elsie Wang (medical student), and Dr Salina Kang (family medicine).

regulatory reforms to ensure equitable and efficient use of health care dollars.

Many students advocated for increased support for medical trainees, including tuition relief, student loan forgiveness, and programs to prevent burnout. Concerns were prominent about the brain drain of Canadian medical graduates leaving to practise abroad, along with a call for national licensure to facilitate physician mobility and service in high-need areas.

Additional key priorities included establishment of a universal pharmacare program, urgent action on the opioid crisis, and reforms to medical assistance in dying policies to strengthen safeguards for vulnerable populations.

Provincial concerns: Health and social system insufficiencies and workforce planning

Trainees expressed strong concerns about emergency department overcrowding, long wait times, and inconsistencies in health care system coordination. They also urged investment in medical education, including expanding training positions, infrastructure, and support for learners.

Trainees urged the provincial government to support the use of digital health tools to improve system efficiency but also stressed the need for equitable implementation, such as a more robust electronic health records system in BC. Furthermore, a team-based system is essential to strengthen existing primary care systems.

Another key concern was addressing the unmet social determinants of health through an intersectional equity lens, particularly for Indigenous people, individuals with disabilities, and those living in poverty. Trainees recommended expanding access to mental health housing, social infrastructure, and programs that match the province's population growth and evolving needs.

Concerns were repeatedly raised about physician burnout, particularly among residents and rural physicians, highlighting the need for urgent workforce planning and sustainable staffing strategies for the province. Parental leave support and administrative load reduction continue to be priorities for trainees.

Moving forward together

These deep concerns and proposals reflect an informed understanding and a passion for health care from trainees who are committed to meaningful change. These voices come from lecture halls, call rooms, emergency departments, inpatient wards, surgery units, and rural placements across BC, and they deserve to be part of the provincial and national dialogues.

As future physicians, we are not only preparing to practise in this system, we are also investing our lives in it. We respectfully call on policymakers, including Prime Minister Mark Carney and Premier David Eby, to engage with these priorities and work alongside health care learners to shape a system that is more accessible, equitable, and sustainable for all Canadians.

—Elsie J. Wang, BSc
UBC MD Student, Class of 2026
—Joban Bal, MD
UBC Resident Doctor
—Philip Edgcumbe, MD, PhD
UBC Resident Doctor

Why physicians need the counsel of a skilled medical librarian in the era of artificial intelligence

As a biomedical librarian with over 30 years of experience supporting British Columbian physicians, I want to highlight the critical role of the College of Physicians and Surgeons of BC (CPSBC) Library and address the profound impact of its closure in 2024, as expressed in letters from physicians and librarians to the *BC Medical Journal*.

Since 1960, CPSBC librarians have supported physicians in maintaining their medical knowledge and practice standards. My mentor, former CPSBC Library director Bill Fraser,[1] emphasized that librarians' value to medicine was undeniable, and that it could be demonstrated. As Dr Caitlin Dunne said, "In losing the Library, we've lost a valuable member of our health care team."[2] Other physicians, such as Dr Margo S. Clarke, have noted that without librarian-mediated access to full-text articles, especially for rare or emerging conditions, staying current would be more difficult.[3] Dr Teresa Marie Kope highlighted the personal impact of the Library closure, citing her reliance on librarians for searches, training, and the *Cites & Bytes* newsletter.[4] Librarians Rachael Bradshaw, Melissa Caines, and Jane Jun from the Health Libraries Association of BC said that equating library value with usage metrics was shortsighted and overlooked the value of services such as rapid clinical searches and systematic review support, which are not easily replaced.[5]

Recommendations

To preserve evidence-based support, the CPSBC should consider the following recommendations:

- Hire a consulting medical librarian for workshops. Contract a professional medical librarian to deliver regular virtual or in-person workshops on search techniques using databases like PubMed, Google Scholar, and Cochrane, as well as artificial intelligence tools like Elicit and Undermind.
- Establish a *BCMJ* column authored by a medical librarian. Create a monthly column in the *BCMJ*, authored by a contracted librarian (at professional rates), to share search strategies, introduce new tools, and provide practical guidance for integrating information skills into clinical practice.
- Hire a medical librarian to curate online resources on the CPSBC website. Develop a dedicated section on the CPSBC website with searchable guides, quick-reference tips, video tutorials, and curated links to high-quality evidence, ensuring access to reliable sources.

Evidence-based return on investment

As Dr Dunne noted, tasks such as mentoring trainees and preparing lectures for professional meetings are more time-consuming

without a librarian's support.[6] For physicians unaffiliated with UBC's medical school and without access to BC's health authority libraries, the CPSBC closure has created significant service gaps. At UBC's Biomedical Branch Library at Vancouver General Hospital, I've seen increased demand from CPSBC members—some with UBC affiliation, some without. Not all BC physicians have access to a qualified librarian or the resources of a decent medical library.

By implementing the recommended low-cost interim measures, the CPSBC can help mitigate the impact of the Library's closure and reinforce the CPSBC's commitment to evidence-based practice.

—Dean Giustini, MLS, MEd
UBC Biomedical Branch Librarian

References

1. Giustini D. A tribute to Bill (Colin) Fraser, medical librarian and mentor. UBC Wiki. Accessed 19 August 2025. https://wiki.ubc.ca/Tribute_to_Bill_(Colin)_Fraser,_Medical_Librarian_and_Mentor.
2. Dunne C. The CPSBC closed our medical library. BCMJ 2024;66:104-105.
3. Clarke M. Closure of the CPSBC medical library. BCMJ 2024;66:192.
4. Kope TM. Closure of the CPSBC medical library. BCMJ 2024;66:191.
5. Bradshaw R, Caines M, Jun J. Re: Closure of the CPSBC medical library. BCMJ 2025;67:47.
6. Dunne C. I miss the CPSBC Library. BCMJ 2025;67:45.

Fewer patients per family physician in BC is the result of intolerable working conditions

The primary care crisis in British Columbia is characterized by a decrease in the productivity of a family physician. Between fiscal years 2011–2012 and 2022–2023, patients continued 5.34 visits per capita annually, but family physicians provided 13% fewer total visits per physician, including 31% fewer longitudinal care visits **[Table 1]**.[1] For decades, family physicians complained of "intolerable working conditions" and "inflexible payment modalities that do not support multiprofessional practices."[2] Their complaints ignored, the interaction of a lack of opportunity, inadequate means, and deteriorating motivation caused a decrease in performance.[3] During the same time span, consulting specialists increased their total visits by 17.6%.[1]

The opportunity for family physicians "to perform a task"[3] in the fee-for-service system is the amount of paid time per visit, regardless of the number of disorders managed, unlike for consulting specialists, for whom "service" means managing one disorder. As disease complexity increased, more time was needed per visit but not provided. In 1977, federal funding of health care was reduced from the initially promised 50% to 23%. BC's Ministry of Health responded by reducing the annual fee-for-service increases to half the annual general inflation rates from 1997 onward.[4] The cumulative effect of that is illustrated by the reduction in constant dollar value of the family medicine in-office visit fee (code 00100) from $17 in 1982 to $32.71 in 2022. At the cumulative general inflation rate of 178.7%, it would have been $47.38 in 2022.[5] The difference of $14.67 represents a 44.9% loss of payment for the service. In 2012, family physicians had the lowest fee-for-service remuneration per average day worked and by 2023 had received the lowest annual increases.[1] That resulted in the ratio of fee-for-service earnings per average day worked of the highest-earning consulting specialist section to the Section of Family Medicine increasing from 3.5 to 4.3, a 23% increase over 11 years.[1] Increases in office staff remuneration and facilities rent in the 1990s and the cost of digitization in the 2000s further reduced after-expense incomes for family physicians.

The means to be "*capable* of performing a task"[3] consists of tools and assistants to

TABLE 1. Total family medicine visits and expenditures and per capita and physician averages in fiscal years 2011–2012 and 2022–2023.

Fiscal year	Total visits by Section of Family Medicine (millions)	Total expenditures (millions)	Visits per capita	Expenditures per visit	Physician count	Average days worked	Total visits per physician	Longitudinal care per physician
2011–2012	26.8	$932	5.36	$34.8	5147	182	5147	1730
2022–2023	28.6	$1234	5.33	$43.2	6302	184	4531	1190
Change	6.3%	32%	-0.6%	24%	22%	1.1%	-13%	-31%

TABLE 2. Total visits per family physician (2011–2012 to 2022–2023) corrected for average days worked (productivity).

2011–2012	2012–2013	2013–2014	2014–2015	2015–2016	2016–2017	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022	2022–2023
5147	5013	4908	4488	4380	4264	4146	4060	4474	4544	4473	4531
100%	99%	99.3%	85.8%	86%	81.9%	80.1%	78%	83.3%	79.5%	82%	87.1%

improve efficiency. In BC, physician assistants are limited to Ministry of Health–operated clinics; all other clinic types lose out on efficiencies that can double the number of patients per family physician and reduce costs per disorder managed.[6] By fiscal year 2013–2014, family physicians had reached a relatively stable average of 5000 visits per physician annually, but in 2014–2015, there was an unexplained 13.5% decrease in visits, which was never regained **[Table 2]**.[1] In 2014, the *UBC Medical Journal* reported that most family physicians in BC had adopted electronic medical records (EMRs),[7] drawing attention to published reports that using EMRs takes more time.[8] The increased time per visit decreased opportunity, further reducing fee-for-service remuneration, and caused anxiety, depression, and burnout. The additional hardware and software that was required increased operating costs.

The motivation "to want to perform a task"[3] began to diminish slowly but relentlessly, the three domains interacting to produce a vicious cycle of ever-decreasing morale, motivation, and lost productivity. Proposed alternative explanations for decreased family physician performance, such as feminization, aging, and lifestyle balance, are inconsistent with consulting specialists' sections not experiencing similar losses of productivity.[1]

A review of BC family physicians' working conditions, going back to the inception of publicly funded health care in Canada, explains the current crisis in access to primary care. The solution is self-evident.

—Gerald Tevaarwerk, MD, FRCPC
Victoria

References

1. Ministry of Health, Health Sector Information, Analysis & Reporting Division. MSP physician resource report: 2013/2014–2022/2023. October 2023. Accessed 26 April 2025. www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msp_physician_resource_report_20123014_to_20222023.pdf.
2. Thirsk R. The lessons of the Columbia disaster can be applied to my current field of health care. Globe and Mail. 1 February 2025. Accessed 26 April 2025. www.theglobeandmail.com/opinion/article-the-lessons-of-the-columbia-disaster-can-be-applied-to-my-current/.
3. John A, Newton-Lewis T, Srinivasan S. Means, motives and opportunity: Determinants of community health worker performance. BMJ Global Health 2019;4:e001790. https://doi.org/10.1136/bmjgh-2019-001790.
4. Barer ML, Evans RG, McGrail KM, et al. Beneath the calm surface: The changing face of physician-service use in British Columbia, 1985/86 versus 1996/97. CMAJ 2004;170:803-807. https://doi.org/10.1503/cmaj.1020460.
5. Bank of Canada. Inflation calculator. Accessed 26 April 2025. www.bankofcanada.ca/rates/related/inflation-calculator.
6. Tevaarwerk GJM. Does the longitudinal family physician payment model improve health care, including sustainability? BCMJ 2023;65:242-247.
7. Grewal GS. Electronic medical records in primary care: Are we there yet? UBCMJ 2014;6:15-16.
8. Sinsky C, Colligan L, Li L, et al. Allocation of physician time in ambulatory practice: A timely motion study in 4 specialties. Ann Int Med 2016;165:753-760. https://doi.org/10.7326/m16-0961.

Time to change the way physicians are trained in Canada

Dr Deena Case's letter [*BCMJ* 2025;67:198] about the high rate of infertility among physicians emphasized that this situation arises from the length of time it takes to train to be a physician in Canada. Consequently, the ova of female doctors are likely to exceed their best-before date prior to the time they are professionally ready to conceive.

She raises a valid observation: Is it *really* necessary that the training to become an effective physician involves so much of a person's adult life? The experience for a member of my family was 4 years to obtain an undergraduate degree and 2 years for a master's degree before acceptance into 4 years of medical school. That was followed by 5 years of specialty training and then over 2 years of subspecialty training, with 1 year out for serious health problems. That is 18 years (well over one-third of one's earning lifetime), paid for out of pocket after high school, before significant earnings begin, as well as putting oneself years behind in the housing market, with no pension to compensate at the end of a career working for the government system. Can such a setup provide the physician workforce for our country?

Next month, my niece's son enters medical school in Denmark, with nothing more than a high school diploma. No wonder the Danes are such a well-provided-for nation. Time for Canada to cut prerequisites and catch up.

—Anthony Walter, MD
Coldstream

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5. Martin G. Was Hippocrates a beginner at trepanning and where did he learn? J Clin Neurosci 2000;7:500-502. https://doi.org/10.1054/jocn.1999.0677.
6. Faria MA Jr. Violence, mental illness, and the brain – A brief history of psychosurgery: Part 1 – From trephination to lobotomy. Surg Neurol Int 2013;4:49.
7. Terrier L-M, Lévêque M, Amelot A. Brain lobotomy: A historical and moral dilemma with no alternative? World Neurosurg 2019;132:211-218. https://doi.org/10.1016/j.wneu.2019.08.254.
8. Paul NP, Galván AE, Yoshinaga-Sakurai K, et al. Arsenic in medicine: Past, present and future. Biometals 2022;36:283-301. https://doi.org/10.1007/s10534-022-00371-y.
9. Budnik LG, Casteleyn L. Mercury pollution in modern times and its socio-medical consequences. Sci Total Environ 2019:654:720-734. https://doi.org/10.1016/j.scitotenv.2018.10.408.
10. Yeh RW, Valsdottir LR, Yeh MW, et al. Parachute use to prevent death and major trauma when jumping from aircraft: Randomized controlled trial. BMJ 2018;363:k5094. https://doi.org/10.1136/bmj.k5094.