The case for serendipity, and what readers say about the *BCMJ*

You arrive home after a long day of seeing patients and collect the mail, scattered across the entryway beside children's shoes and cardboard boxes. Among the flyers and bank statements is the *BCMJ*. You recognize it instantly by its distinctive, if enigmatic, cover artwork. As you wait for the water to boil while making dinner, you leaf through the journal's pages to discover that a friend from medical school has published a piece in the Clinical Images section. It's not directly relevant to your specialty, but it's interesting to see what she's up to in the remote community where she practises. A clinical article on asthma treatment in BC also catches your eye—not something you typically manage in your practice, but relevant nonetheless, since one of your children suffers from asthma, and wildfire season will soon be upon us (something else you've read about in a prior issue of the *BCMJ*). You pause at a letter responding to last month's President's Comment, addressing government policies that could affect physicians across the province.

As family physicians or specialists, we all have our go-to resources for continuing medical education. But given the countless niches and the depth of medical knowledge that exists today, these resources rarely overlap across subspecialties. That's the beauty of a general medical journal—even if you aren't seeking a specific article, many turn out to be relevant, either directly or indirectly, because they're local. The *BCMJ* keeps doctors connected outside of their clinical lanes. My message to potential authors is this: More of your colleagues will read your research if you publish it here than almost anywhere else. Medicine doesn't happen in silos, nor should our reading.

The act of browsing strengthens the sense of community across our province

In June 2025, we completed our most recent reader survey, with 795 responses from 24 700 surveys sent, a modest response rate but comparable to prior surveys in 2022 and 2016. Of those respondents, 39% were family physicians, 40% were specialists, 17% were retired, and 4% were students. The majority (57%) were between 35 and 64 years of age, while 36% were over 65 years of age. The survey results are presented in greater detail later in this issue, but a few standouts deserve mention:

- The *BCMJ* is, increasingly, a journal that people want to read. Sixty-two percent of respondents said they "always" or "usually" read the journal, compared with 40% in 2016 and 2022. At a time when publications are struggling to hold readers' attention, this growth in loyalty is remarkable. Physicians value the *BCMJ* as a source of information about what is happening in BC's health care system and with its health care providers.
- Serendipity is our strength. Most readers (58%) said they browse for interesting headlines, which reinforces the importance of discovery. A digital algorithm may not serve up the article you didn't know you needed, but the *BCMJ* can, and often does. The act of browsing strengthens the sense of community across our province by exposing us to topics beyond our own specialties.
- Print still works. Across all ages, the *BCMJ* maintains strong support for a print edition, with 74% to 88% of readers aged 35 to 65 saying they prefer it. This is consistent with 2022, when 82% reported the same. Print invites that flip-through moment that leads to unexpected discoveries—pieces that might otherwise be buried in an inbox. It also encourages communication and supports our work in a way that feels tangible and enduring.

We invite you to read more on page 334 of this issue and share your reflections with us. The survey results confirm what we're doing well, but they also highlight areas for improvement—whether through indexing, increased visibility, or digital evolution. As I mentioned in June when I asked you to complete the survey, the *BCMJ*'s future is shaped by its readers. ■

—Caitlin Dunne, MD

Opportunistic salpingectomy: General surgeons can reduce ovarian cancer in British Columbia

British Columbia was the first jurisdiction in the world to introduce opportunistic salpingectomy in 2010.[1] Opportunistic salpingectomy refers to the removal of the fallopian tubes during hysterectomy or instead of tubal ligation, while leaving the ovaries intact. It has proven to be an effective means to prevent ovarian cancer, particularly serous ovarian cancer.[2,3]

As there is no effective screening for ovarian cancer, it is often diagnosed at an advanced stage, making prevention key in reducing morbidity and mortality associated with ovarian cancer. High-grade serous cancer (HGSC) is the most common and aggressive subtype of ovarian cancer and mostly arises from the fallopian tube epithelium.[4] The risk of developing ovarian cancer in the general population is 1.4%;[5] however, this risk significantly increases in those with the germline mutations *BRCA1* and *BRCA2* (a cumulative risk of up to 75% and 34%, respectively).[6] Therefore, prophylactic bilateral salpingo-oopherectomy is recommended in this higher-risk patient population. However, to reduce the risk of ovarian cancer in the general population—where 80% of ovarian cancers develop—prophylactic removal of the ovaries is not advised, considering the risk of early iatrogenic menopause, coronary artery disease, osteoporosis, and mortality.[7] In women who have finished having children, removing the fallopian tubes provides an effective strategy to reduce HGSC risk without any hormonal consequences.

Gynecologists offer salpingectomy in patients undergoing pelvic surgeries such as hysterectomy or in place of tubal ligation as a sterilization method. Studies have shown no increased risk of complications such as bleeding,[8] ureteric or ovarian injury (oral communication from Dr Gillian Hanley, associate professor, UBC Faculty of Medicine, 8 September 2025), or conversion to open surgery[9] when opportunistic salpingectomy is added to the index surgery. In a recent study, Hanley and colleagues compared observed and expected cases of HGSC in patients undergoing opportunistic salpingectomy and demonstrated a significant reduction in ovarian cancer rates (0% versus 5.27%; 95% CI, 1.78-19.29).[3]

Considering that general surgeons commonly perform abdominal surgeries and the relative safety and ease of performing opportunistic salpingectomy, their involvement will allow for significantly more salpingectomies at the population level, contributing to an overall reduction in HGSC. Studies so far have supported opportunistic salpingectomy during laparoscopic cholecystectomy without increased complication rates, with an average additional operative time of 13 minutes.[10] Although in 30.5% cases, an additional port placement was required during laparoscopic cholecystectomy, this should not have significant consequences for patients or their surgical outcome. Opportunistic salpingectomy can also be safely and conveniently performed during other nongynecological pelvic operations, such as colon and rectal resections. Unpublished data from BC support performing opportunistic salpingectomy during colorectal surgery, with only 4 minutes of added operative time.

Despite the current trends and evidence, more widespread buy-in from general surgeons is needed. The somewhat slow uptake can be explained, in part, by issues with remuneration, added operative time, a surgeon's comfort level to perform the procedure, and medicolegal concerns, particularly related to patient selection and appropriate consent. There has been excellent work done by British Columbia health care leaders Drs Gillian Hanley, Heather Stuart, and Scott Cowie to encourage and support general surgeons in performing opportunistic salpingectomy. These measures include creating a new billing code for general surgeons performing opportunistic salpingectomy; patient pamphlets in 13 languages to help with patient education; and patient videos explaining the procedure, including its indications and benefits, to facilitate informed consent. There is also a dedicated group of gynecologists around BC who are available to help support general surgeons in performing opportunistic salpingectomy. On Vancouver Island, we have been able to secure funding to raise

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Opportunistic salpingectomy resources

Additional resources about opportunistic salpingectomy are available on the Specialist Services Committee website (https://sscbc.ca/os):

- **For patients:** *Opportunistic Salpingectomy*—ovarian cancer prevention educational pamphlet
- **For physicians:** *Opportunistic Salpingectomy (OS)*—consent handout
- **For general and urologic surgeons:** Video: *Expanding Uptake for Opportunistic Salpingectomy in BC*

WWFLPYD (whenever we feel like paying you, doctor).

Second, MSP does not pay equitably for a lot of marginalized folks. They won't like that I'm saying this, but it's simply objectively true. I do a lot of free work at Kelowna General Hospital. I see this most often with folks who are marginalized and may not have the resources or capacity to keep up MSP coverage. MSP points to the Enhanced Urgent Care Coverage Program (EUCCP). But in real life, the EUCCP has worked 0/8 times for me, because to get paid, I'm supposed to collect "proof of residency"—a utility bill, an employer letter, or a signed questionnaire—from the patient, someone I am involuntarily admitting to a windowless locked room while administering antipsychotics and sedatives they do not think they need. The last time I tried to ask a patient in this situation if he had a utility bill so that I could get paid, he quickly reminded me what he thought of me at that moment. I will not be doing that again. (He also doesn't have a hydro bill, because he doesn't have a home.) But, as a firm believer that they would pay me for the work I did, when I first moved to BC, I submitted multiple EUCCP claims anyway. Success rate: 0%. Also, FYI, you are not contacted about the claims. They just . . . disappear. No call. No explanation. And when you call them? And you get transferred to the right person? They dismiss you because you didn't get the proper documentation from the patient you were putting in four-point restraints.

Show me another business that tolerates this. Most businesses set payment terms and enforce them. But BC doctors? We've normalized dysfunction. Maybe because many BC physicians don't realize that in other provinces, you actually get paid for every code you bill. On time. We are contractors providing services to the Province of BC. Why are we (physicians) taking the loss? That's for the BC government to solve.

We are not contracted by the patients themselves. I would argue that it's not very ethical (and *certainly* not very practical) to send an invoice to a patient you involuntarily kept in hospital for days while giving them medications they didn't want or think they needed.

This isn't just about physician pay—it's also about care. When the system makes it impossible to be paid for treating the most marginalized patients, it creates pressure to spend less time on them. That's not the health care system we claim to be.

We weren't trained to run businesses. This is hugely advantageous for the system. We don't know that this isn't normal. Oh, and by the way, don't contact your hospital for help. They would rather bring in their lawyers to ensure they don't have to help you. Trust me. I have it in writing: your hospital is not responsible for helping doctors get paid.

I, like you, should be getting paid for 100% of the contracted work I do within our public system. What would fix this?

- Real timelines for MSP payments. I suggest net 15 or net 30, in keeping with insurance company standards.
- Charging interest. We (doctors) should be charging interest on unpaid claims, like every other business out there.
- A workable path to pay for emergency and involuntary care that doesn't hinge on documents patients in crisis cannot and will not produce. We (doctors) are not contracted by patients. We are contracted by the Province. If somebody is in your province, and we are providing emergency care for them, we should get paid—even if they are experiencing homelessness, schizophrenia, or substance use disorder.
- Hospital processes that start coverage support at admission—not after discharge, and not never.

We are the owners of our practices—whether we claim the title or not. It's time to act like it. Because honestly, in what other business would this be acceptable?

—Marie Claire Bourque, MD, MSc, FRCPC, DABPN
Kelowna

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awareness and run multidisciplinary education sessions to encourage participation from general surgeons in opportunistic salpingectomy.

With increased awareness, women in BC will have the opportunity to discuss opportunistic salpingectomy with their primary care and specialist physicians, allowing for a more widespread practice of this procedure across the province. Recent data from the United States suggest that taking advantage of all surgical opportunities to offer patients opportunistic salpingectomy could prevent up to 25% of ovarian cancers.[11] No new treatments have provided such a significant improvement in survival for ovarian cancer patients in the past 50 years. Therefore, the potential to reduce the morbidity and mortality from ovarian cancer by expanding opportunistic salpingectomy to general surgery is not trivial. In an elective setting, opportunistic salpingectomy is a low-risk, relatively simple procedure that can be carried out with little to no extra resources required intra-operatively, and I strongly encourage general surgeons to incorporate opportunistic salpingectomy into their practice. ■

—Sepehr Khorasani, MD, MSc, FRCSC

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The power of physician leadership: Your voice, your vote

As physicians, we have chosen a profession grounded in service, advocacy, and the pursuit of better health for all. Yet our responsibility does not end at the bedside. In a time of profound change in our health care system—with new models of care, shifting patient needs, and mounting pressures on resources—physician leadership has never been more essential.

My tenure as president of Doctors of BC has provided me with a unique vantage point on the transformative power of physician leadership. When I assumed this role, I felt both humbled and challenged by the task of representing colleagues across the province. The stakes were high, and the learning curve was steep. But the experience quickly reaffirmed that when physicians step into leadership, we have the power to influence policy, strengthen collaboration, and advance the profession in ways that directly benefit patients.

Some of the most inspiring moments of my term occurred during conversations with frontline physicians who were struggling with burnout and systemic challenges. Discussing the challenges, exploring creative and actionable strategies for improvement, and seeing policies and processes that support physicians' abilities to deliver care and improve patient access and outcomes leave me with a deep sense of hope. It is a reminder that change is not merely a disruption—it is an opportunity. With courage, compassion, and collective effort, we can turn moments of uncertainty into catalysts for lasting improvement.

Leadership is not simply about holding a title; it is about using one's clinical insight, lived experience, and values to help shape the future. It is about finding common ground and listening to the perspectives of others, even in the most difficult discussions, and guiding our profession toward collaborative solutions that serve patients and medical professionals alike.

It is now time for the next round of elections for Doctors of BC's president-elect, Board, Representative Assembly, and statutory committees. Electronic voting opened on 27 October, and I urge my colleagues to cast your votes before the 27 November deadline. This is a pivotal moment for BC health care. Change is here, and with it comes the opportunity to do great things. By lending your voice and your vote, you can help shape the direction of our health care system at this critical juncture. You can learn more at www.doctorsofbc.ca/elections.

To all my colleagues, I extend my deepest gratitude for your unwavering commitment to patients and one another. The bond we share as physician leaders, grounded in mutual respect, encouragement, and shared purpose, is one of our greatest strengths. Together, we can support each other in facing challenges, amplifying our collective voice, and creating a stronger, more resilient profession for the future, because together is our superpower. ■

—Charlene Lui, MD
Doctors of BC President

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