Letters to the editor

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Re: Health outcomes of patients in the Complex Chronic Diseases Program

We thank the authors for their illuminating article [*BCMJ* 2025;67:174-181]. We appreciate the dedication of the Complex Chronic Diseases Program (CCDP) to a group of patients who are stigmatized and profoundly underserved by our health care system. These patients suffer deeply, and their distress deserves compassion and appropriate care.

We disagree with the authors' conclusion that the absence of meaningful clinical improvement in their study indicates that patients with fibromyalgia and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) have illnesses that are too "severe and persistent" to respond meaningfully to treatment. We believe the more urgent implication of this study is that these patients' suffering was not ameliorated because the treatment provided by the CCDP does not address their complex psychosocial needs.

Patients with fibromyalgia and ME/CFS have a high proportion of childhood physical abuse, emotional neglect, and sexual trauma.[1,2] This trauma contributes to profound attachment disruptions and, when combined with the chronicity of their illness and the stigma they face, fosters deep epistemic mistrust toward the health care system. Establishment of a longitudinal, trusting relationship with a consistent care provider offers a supportive attachment, which is essential for these patients to engage in care and experience recovery.

The CCDP model, focused primarily on specialist consultations and other short-term interventions such as self-management, pacing, pharmacotherapy, and group medical visits, is thus fundamentally limited. The pursuit of these treatments is ineffective, as the authors conclude, and is, therefore, a disservice to our patients.

The treatment of complex chronic diseases necessitates individualized, holistic, long-term, and relationship-centred care. Primary care physicians are well positioned to provide this care, as is offered by the High Complexity Care Team in Victoria. Psychiatrists, who were strikingly absent from the interdisciplinary team members mentioned in this article, are also well positioned to provide this care, as is offered by the St. Paul's Hospital Complex Pain Centre.

Treating complex chronic diseases requires systems that are willing to centre access to individualized, longitudinal, and whole-person care that is trauma informed. Programs like the CCDP are uniquely positioned to lead this charge, but only if they are willing to move beyond their short-term, consultative, and biological frame.

—Spencer Cleave, MD, CCFP
Medical Director, High Complexity Care Team

—Thea Gilks, MD, FRCPC
Psychiatrist, St. Paul's Hospital Complex Pain Centre

—Isaac Rodin, MD
Psychiatry Resident, UBC
St. Paul's Hospital Complex Pain Centre

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Authors reply

We thank the *BCMJ* for sharing the letter from Cleave and colleagues[1] about our article and the authors for their perspective on the needs of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and fibromyalgia patients in BC. We concur with their assessment that patients with complex chronic diseases have often been "stigmatized and profoundly underserved by our health care system" and that they deserve appropriate care. We thank them for recognizing the dedication of the only provincial reference service for these patients.

However, our team disagrees with the assessment that the conclusion of our article indicates that ME/CFS and fibromyalgia are "too severe and persistent to respond to treatment." Instead, the article concludes that there were some improvements in mental and physical health indicators and the severity of ME/CFS, *which were nevertheless* limited.[2] The intended conclusion was to point to the chronic and individualized nature of these diseases and the difficulty of treating them, not least due to the current absence of evidence-based curative treatments for ME/CFS,[3] not that they are untreatable. The Complex Chronic Diseases Program (CCDP) prioritizes the biological as well as the psychosocial health of patients and has a full team of interprofessionals, including mental and physical health specialists. While overall improvements were small, it is significant that mental health scores of patients with complex chronic diseases improved during the COVID-19 pandemic, a period when the general population experienced a particularly high risk of developing or worsening mental health problems.

In our article, we also emphasize the importance of "earlier diagnosis and intervention, particularly at the primary care level." This is particularly important having in mind that most patients presented late to the specialized service, years after developing the disease. We have previously reported on the importance of early diagnosis and management as key to improving the prognosis of those with ME/CFS.[4] This is true for chronic diseases in general, for which treatment becomes increasingly more challenging in later disease stages and disease complications limit the impact of treatment.[4] We offer a path to better outcomes, based on the "integration of primary care, community providers, and specialist expertise," and highlight the importance of "continuing education and research." Education of health professionals, in particular those in primary care, would be key to early diagnosis and management.

Regarding the authors' claim that childhood trauma can explain the disease etiology in part or in full, the evidence of childhood trauma as a risk factor for complex chronic diseases is rather weak and nonspecific. Studies suggesting this relationship have been of poor quality (as reported by Häuser and colleagues' meta-analysis, cited by Cleave and colleagues in their letter).[5] That study specifically indicated that "study quality was mostly poor," confounding the findings.[5]

The study by Gardoki-Souto and colleagues, also mentioned in the letter, is a cross-sectional study, and thus also inappropriate for determining causality.[6] Moreover, a high proportion of patients in the study were recruited from mental health services, which generates significant selection bias in the sample; the potential for bias is further increased by the absence of controls.

Trauma is not uncommon and should be considered in any patient when assessed at health services. This should be addressed and managed accordingly. The CCDP has been a trauma-informed service since its inception. This means we fully consider trauma as possibly present in any patient who reaches the program and tailor care with respect and sensitivity accordingly. This does not in any way suggest, let alone demonstrate, causality between trauma and complex chronic diseases. Suggesting childhood trauma as an explanation for complex chronic diseases is very problematic, is not patient centred, and does a disservice to this often-neglected population by psychologizing physical health problems.

The treatment of complex chronic diseases is indeed longitudinal and, as such, includes multiple contact points with the interprofessional team. We have also worked together with primary care to best serve the continuing needs of the patient population. Indeed, we need to continue to fight the stigmatization of this patient population, including that observed within the health sector,[7] which has more than often hampered the well-being and management of this patient population. Good science and health practice are important steps.

—Luis Nacul, MD
Clinical Associate Professor, Department of Family Practice, UBC

Note: The study team is no longer connected with the CCDP. The statements in this letter speak only for the program in the context of the original article.

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Why doctors must start thinking like CEOs

Maybe I'm burned out, sure, but maybe I'm just sick of not getting paid for the work I do. I'm a psychiatrist, and it is shocking to me that we physicians routinely don't get paid for work we've done.

In BC, the Medical Services Plan (MSP) often doesn't pay. We get cryptic notes like "BH—This claim will be processed on a future remittance statement." No date. No clarity. As of the time of submission of this letter, I have over $3000 in accounts receivable from BH-coded claims from MSP, spanning months. No indication of what they are doing or when the claim will get paid. Are they drawing cards from a hat to figure out when they will pay those claims?

Next time I go to file my income tax, I'm going to write "BH" on the provincial portion. And when they call me and ask me for details, I will tell them, "This will be processed in the future. That's all I can tell you at this time."

This is not true in all situations. I get paid for 100% of the work I do in my outpatient clinic. And I get paid on time. It's the emergency work, the hospital work, the work I do with marginalized folks that doesn't get paid. And there are two reasons for that.

First, we do not demand that MSP pay on time. Do other businesses have problems getting paid? Maybe, but they go after their payments. They go to collections. They don't work with those clients anymore. Months can go by without getting paid for certain claims. And we are helpless. Try doing accrual accounting with that. Forget net 15 or net 30. In BC, with MSP, it's net

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

Continued from page 309

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

Acknowledgments

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References continued on page 313