BCMJ
A Doctors of BC Publication

Dr Adam Thompson

Doctors of BC president, 2026

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In 2022–23, only 6% to 7% of internal medicine specialists, pediatricians, and psychiatrists were registered in rural and remote areas. "Regional disparities in medical specialties in rural British Columbia" begins on page 22.

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Mission: The *BCMJ* is a general medical journal that shares knowledge while building connections among BC physicians.

Vision: The *BCMJ* is an independent and inclusive forum to communicate ideas, inspiring excellent health care in British Columbia.

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Quality: Publishing content that is useful, current, and reliable.
Connections: Sharing diversity of thought and experiences from across the province and promoting communication between BC doctors.
Impact: Striving for healthier patients and communities by amplifying physicians' voices, opinions, research, and news.

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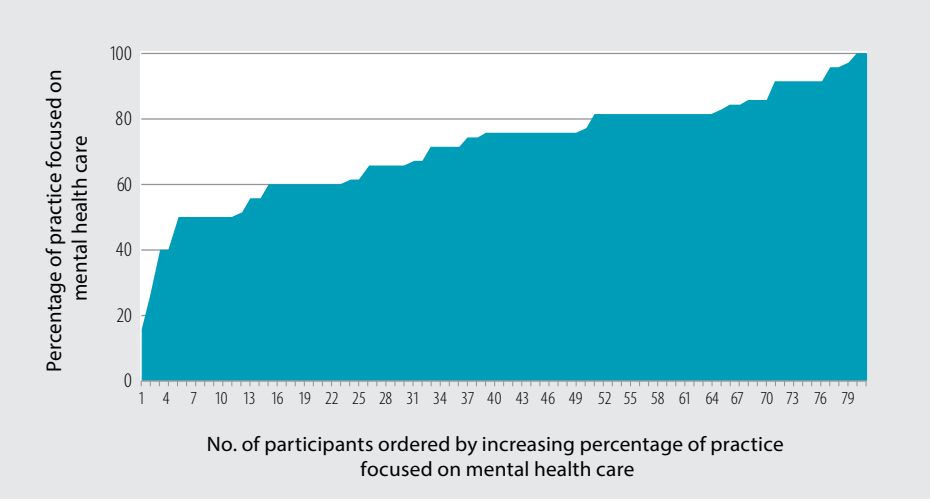

Mental health care now comprises most of the care that community-based consultant pediatricians provide, and this has increased significantly over the last decade. "Community-based consultant pediatrician perspectives on child and youth mental health in British Columbia" begins on page 29.

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Will Big Food outsmart GLP-1s?

Weight-loss medications have exploded in popularity, and they are shaking the foundations of Big Food. As people eat less junk food, major packaged-food companies are seeing the impact on sales and pivoting in an attempt to maintain consumer appetites.[1,2]

Glucagon-like peptide-1 (GLP-1) receptor agonists were first approved in the United States in 2005 for the treatment of diabetes and in 2014 for weight loss.[3] Their cultural footprint expanded dramatically after semaglutide received approval for weight management in 2021.[3,4] Today, whether scrolling social media or chatting with friends, patients, or colleagues, it's impossible not to notice the sweeping influence of Wegovy, Ozempic, and similar medications. According to a recent report, 5% of adults in the US are taking GLP-1 agonists, and 12% have tried them—and usage may increase tenfold in the coming decade.[5] Estimates suggest that more than 1.4 million Canadians are now using GLP-1 receptor agonists.[2]

Snack-food, confectionery, and soft-drink sales may be hit hardest because they depend heavily on frequency and impulse, which can be affected by medication-induced appetite suppression.[6]

Food companies are already responding. During PepsiCo's 2025 Q1 earnings call, the CEO highlighted the company's "fiber and hydration solutions" when asked about the launch of oral GLP-1 medications. He acknowledged the shift in consumer habits: "The other thing we're seeing in GLP consumers is that they're keeping our brands in their repertoire. . . . They're eating less quantities, so our offerings in the small portions—whether it's multipack or some other options . . . will make sure that our brands stay relevant to those consumers."[5,7]

PepsiCo is hardly alone. Many corporations are trying to transform GLP-1-induced challenges into lucrative opportunities. Nestlé has launched Vital Pursuit, a new line of foods marketed specifically as "companions" for GLP-1 weight-loss medication users.[8] Conagra Brands is tagging select items with an "On Track" badge to signal that they are "GLP-1-friendly." Meanwhile, companies like Coca-Cola and General Mills have already begun tweaking existing offerings to appeal to consumers with smaller appetites. Food innovation firm Mattson has reportedly explored numerous new concepts like brownie cubes and frozen "hydropops" designed for GLP-1 users.[9]

As Tomas Weber wrote in his *New York Times Magazine* piece "Ozempic could crush the junk food industry. But it is fighting back," "There is little the industry hasn't tried to keep health-conscious consumers eating."[10] The food industry has always rebranded to keep pace with diet fads, introducing fat-free cookies, diet frozen entrees, and plant-based fast foods. "For decades, Big Food has been marketing products to people who can't stop eating," he writes. "And now, suddenly, they can."[10]

This raises uncomfortable questions. Will Big Food find ways to make ultra-processed foods even more irresistible? Over the years, salt has become saltier, crunch more exaggerated, and aromas more engineered and provocative.[10] If companies intensify these tactics, could that blunt the effectiveness of GLP-1 medications by working around satiety cues? And what about those not using weight-loss drugs? They may soon face an even more bewildering landscape of "better-for-you" products that are still ultra-processed. The stakes are particularly high for youth, who already obtain more than 60% of their total energy intake from ultra-processed foods.[11] Youth are also especially vulnerable to marketing and health-washed branding.

What are your thoughts on GLP-1-optimized products? It seems to me that while GLP-1 medications may be shrinking waistlines, Big Food is working hard to ensure its bottom line doesn't follow suit. ■

—Caitlin Dunne, MD

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Traditional medicines and healing practices

When I entered medical school almost 20 years ago, topics about Indigenous people (First Nations, Métis, and Inuit) were put under the umbrella of Indigenous health. The topics focused on health disparities between Indigenous and non-Indigenous people, social determinants of health, and harms caused by culturally unsafe care and discrimination. As outlined in one of my previous editorials,[1] these topics are less about Indigenous people and more about the impacts of colonialism and racism that Indigenous people have endured. The logical questions that follow are: What is Indigenous health, and how can we advance it?

Indigenous health is defined by Indigenous people; is rooted in their traditional ways of knowing, being, and healing; and it outlines their own pathways to wellness. Each Nation will have unique health-related values tied to its traditions, lands, and laws. Cultural and traditional wellness practices provide the foundation for Indigenous health. This is why the ability to access and use traditional medicines and practices is outlined as a fundamental right in article 24 of the United Nations Declaration on the Rights of Indigenous Peoples and the Truth and Reconciliation Commission of Canada's Call to Action #22. With this foundation, Indigenous communities can augment their traditional healing practices with best practices from Western medicine to lead clinical research, education, and services that are designed *for* them, *by* them. This is commonly referred to as a Two-Eyed-Seeing approach, originally coined by Mi'kmaw Elder Albert Marshall, and is used to describe the use of both knowledge systems to ensure the best possible outcomes for Indigenous people.

There are many Indigenous models of health, with the medicine wheel being a well-known holistic health model attributed to Plains Nations. The model has many teachings, and I'll highlight just a few of them. My favorite concept of the medicine wheel **[Figure]** has culture in the centre, depicting the importance of culture for our health and healing.[2] The next ring of the circle depicts that the health of a person has four elements: physical, emotional, mental, and spiritual. This is like the biopsychosocial model taught from a Western lens. Our Elders would teach that each part of the medicine wheel impacts the other parts, and that to restore health, we need to find balance. The outer circles reflect that an individual's health is influenced by the health of their families, their communities, and all of creation. This is rooted in the belief that we are all connected, and we need to maintain respectful relationships for all to thrive.

The beliefs and practices that help to restore health vary widely among different

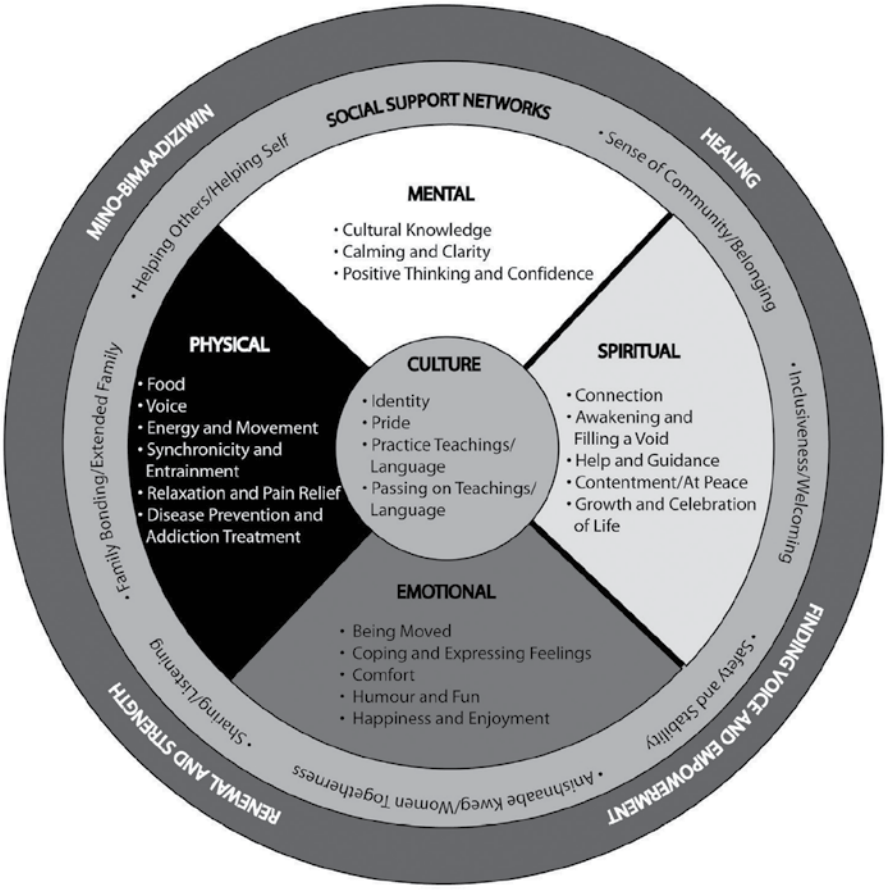

FIGURE. Aboriginal women's hand drumming circle of life framework with themes.[2]
Source: "Hand drumming: Health-promoting experiences of Aboriginal women from a Northern Ontario urban community" by Ghislaine Goudreau, Cora Weber-Pillwax, Sheila Cote-Meek, Helen Madill, and Stan Wilson. Published in the ***International Journal of Indigenous Health*** and made available under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International licence (https://creativecommons.org/licenses/by-nc-nd/4.0/).

Indigenous groups and Nations; however, knowing a few key differences can be helpful for health care providers. The two main categories of traditional wellness are traditional medicines and traditional healing practices. Traditional medicines are medicinal herbs, teas, and salves derived from plants and animals that are harvested and prepared for treatment of specific ailments. Traditional healing practices can include ceremonies, energy work, physical practices (e.g., massage), and counseling. These practices vary widely; however, they all work by attuning all aspects of a person's medicine wheel. Of note, most traditional approaches to health focus on prevention and include teachings about the importance of nutrition, fasting, activity, and ceremony to help guide people to live long, healthy lives in balance with the world around them. As physicians, being curious and open to discuss how and if Indigenous people are using traditional medicines and practices is a key component to cultural safety; however, it is important not to assume that all Indigenous people use or would want to use these methods of healing and not to misappropriate these teachings.

As we find ourselves deep in the winter months, I reflect that this is the time of year during which many northern Indigenous people would enter months of relative solitude in our winter camps. We would often co-locate in smaller family groups and take advantage of the shorter days to rest, pass on our oral histories, create art, build and repair items, and hold ceremonies. The other seasons were quite labor intensive from harvesting and collecting food and raw materials, as well as from larger social gatherings and traveling around the territory. Although the winter months posed a significant threat to our survival from exposure to the elements and a lack of food, it became a crucial time for rest and rejuvenation.

In our fast-moving world, where we are often out of sync with the natural cycle of growth and rest, it is important to remember that rest is crucial. Constant growth and harvesting of ourselves and the world lead to depletion and is not sustainable. I hope you can take time to attune to your medicine wheel in preparation for the tumultuous seasons ahead. ■

—Terri Aldred, MD

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Letters to the editor

We welcome original letters of less than 500 words; we may edit them for clarity and length. Email letters to journal@doctorsofbc.ca and include your city or town of residence, telephone number, and email address. Please disclose any competing interests.

Excluding individuals who use substances from research: Considerations

Substance use, including the use of illicit drugs and alcohol, continues to be prevalent in our communities, with toxic drug use as the leading cause of death in British Columbia for those who are 10 to 59 years of age.[1] While valid methodological reasons exist for excluding individuals who use substances from research, including concerns about drug–drug interactions or increased medical risks, the rationale for exclusions should be explicit and supported with sound scientific reasoning for research ethics boards (REBs) to consider. Without thorough evaluation, people who use substances may be excluded due to unconscious biases that contribute to stigma.

The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2022)* requires researchers to avoid unjustified exclusions.[2] Such exclusions diminish sample representativeness, compromise reproducibility, and restrict the development of effective interventions, putting these populations at risk of becoming therapeutic orphans.[3] Yet, REBs continue to see clinical research studies exclude individuals who use substances without clear justification, and few resources exist to guide REBs in their appropriate inclusion.

To understand the practice of REBs excluding people who use substances, we conducted an online survey among REB members across BC. The study was approved by the University of British Columbia's Behavioural REB. The results demonstrate the need to support REBs in navigating the complex issue of exclusion, such as through the implementation of a standardized provincial tool.

Survey responses show that most respondents have reviewed studies with an exclusion for people using illicit substances and alcohol. However, only half were confident in their REB's awareness of their own biases toward this population. When asked about the presence of specific anti-stigma/harm reduction policies, about half confirmed their institution had policies geared toward the inclusion of people who use substances, while the remainder reported it did not or provided no response to this question.

In 2019, estimates showed that 4.6% of BC respondents reported using illicit drugs and 77.2% reported using alcohol within the past year.[4] Therefore, we invite researchers to consider how they will deal with those who disclose substance use to the study team and to account for individuals who, despite using substances, may choose not to disclose due to stigma or other concerns.

The Interior Health Authority created the Research Applications Checklist for Exclusion Criteria in response to the survey results; it represents a step toward fostering reflection, encouraging discussion, and supporting anti-stigma efforts in health care that can be readily adopted by REBs. To receive a copy of this tool, please contact Dr Silvina Mema (Silvina.Mema@interiorhealth.ca).

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Valuing community through positive connections

As I share my first remarks with you, let me begin by thanking you for the deep care and commitment you offer to British Columbians. Despite significant challenges, you continue to show up—often at the expense of your own well-being. I am deeply grateful to each of you for your dedication, compassion, and persistence in caring for others, even when it's hard to care for yourself. When we stand together and stay connected, we have the power to shape a better health care system—one that serves our patients and strengthens our ability to thrive in the profession we love.

I've always valued my colleagues and have been motivated by a sense of justice on their behalf. My first leadership experience—like many of yours—began organically. As a 25-year-old resident, I challenged a hospital board in the UK to secure fair on-call pay for my colleagues and myself. We won. That experience shaped me. My commitment to our profession is unwavering: I will always advocate for you, and when the moment calls for it, I will fight for you.

I've also learned that leadership must be pragmatic. We must seize opportunities when they arise—such as with the Longitudinal Family Physician Payment Model—and remain agile in our advocacy, adapting to ensure we achieve meaningful progress. This balance between conviction and flexibility is essential during challenging times.

We face a health care system in crisis. Physicians are walking away from a system that is failing them and their patients. Specialists are suffering from moral distress due to long wait lists and a lack of resources. Emergency departments and intensive care units are closing. Primary care, despite an improved remuneration model, remains too under-resourced to attach all the people seeking a family physician. The development of effective team-based care, led by physicians, is one crucial way to support both patients and physicians. Fiscal austerity looms, and the climate crisis will continue to add further strain on our system, our patients, and the communities we serve.

I've had the privilege of calling the Comox Valley home for the past 15 years. When I left the UK, I vowed never to take on another leadership role in medicine. Yet here I am—because this community reminded me what connection truly means, and how valuing it through leadership sustains us. The Comox Valley grounds us in nature—mountains, lakes, and ocean—each season bringing beauty and change. The opportunity to take time away from practice, with my mountain bike or skis, helps me escape into nature to nurture my own well-being.

As we enter this new "season" in health care—one marked by uncertainty, but also transformation—we must do what we've always done: adapt, learn, and keep showing up. I've watched my community evolve—from knowing nearly everyone on the main street to knowing only a few, from a close-knit group of hospital colleagues to a scattered network across various clinic offices. And yet we strive to stay connected through our divisions and medical staff associations—organizations driven to build positive connections among physicians, and between physicians and their communities. Striving to ensure all of us engage in these organizations will allow us to be authentic with one another.

This is my hope for all of us: to let go of unnecessary expectations and allow ourselves to show up authentically to build positive connections and community. When you meet me, you'll find the same Adam my patients, friends, colleagues, and family know—and, I hope, the same Adam you'll come to know.

As president-elect, I've had the privilege of attending many gatherings focused on physician health, and one message rings clear: we must prioritize our collective resilience and well-being. In the year ahead, my focus will be on building resilience together and harnessing that resilience to care for ourselves and drive meaningful change. I want to explore how we can deepen our positive connections with each other, with our health care partners, with our patients, and within our broader communities.

I am here to serve you—to support you in these positive connections, leading with authenticity, and creating communities where we feel safe, valued, and whole. Because through genuine positive connection, we build community. And through community, we build resilience—and the collective power to shape change. ■

—Adam Thompson, MD
Doctors of BC President

Dr Adam Thompson: Connection above all else

Dr Thompson, the new president of Doctors of BC, started his 1-year term in January 2026 and spoke with *BCMJ* editor-in-chief Dr Caitlin Dunne in December.

Caitlin Dunne, MD

It's very nice to meet you; congratulations on your new role as president of Doctors of BC. For our readers who don't know you yet, perhaps you'd like to start with an introduction.

I'm Adam Thompson, a family doc in Courtenay, on Vancouver Island. I'm married to Emma, a psychotherapist, and we have two boys. We moved here from the UK in 2011. The boys are now both at UBC Okanagan, following two different paths. One is possibly heading toward medicine—we'll see. He's doing a bachelor of neuropsychology at the moment. The other is doing a bachelor of digital media, and he's head of sports photography at UBC Okanagan—he wants to become a sports photographer.

And you have a busy, full-time family practice in Courtenay. How did you balance career and family after you immigrated?

I made sure to protect space to be with my family, the boys in particular. It's important that boys have a positive male role model when they're growing up, projecting the caring side of masculinity. My wife and I made sure to take time away from work on the weekends when we could—we'd go skiing or biking together, or even down to the pub as the boys grew up, just to spend intentional time and be present. Our jobs are busy—we all know that—but there is an interdependency between all the spaces in which we exist, meaning that work has to give way to other parts of life at times.

I believe we need to be humans first across all aspects of our life—family, friends, and community; in our professional role; and particularly in leadership.

More than anything, our families—and *family* can mean whatever you want it to mean, whatever your place of comfort is—are what ground us in the work we do as physicians. And I believe we need to be humans first across all aspects of our life—family, friends, and community; in our professional role; and particularly in leadership.

I agree. As a fertility doctor, I find myself telling people every day that there are many ways to build a family. What did your family think about you wanting to take on the job of president of Doctors of BC?

We're always supportive of anything any of us wishes to try to achieve. With Emma being a psychotherapist, we spend a lot of time talking; communication is key. The boys are excited that I might be popping over to Kelowna occasionally because of work, so there's an opportunity to connect and catch up. Emma understands that I'm going to be away more, but at the same time, there will be opportunities for her to be with me at some events, and we'll be chatting often. She's fully supportive, as was I when she chose to do a master's degree in psychology. That, for me, is the value of family: it's the foundation from which we can go out and explore the world.

Tell us about some of your observations or learnings from your role as president-elect over the past year.

I can't remember the last time someone came from the Board to become president. I've been vice-chair and chair of the Board, I led the organization through leadership change, I led the development of the current strategic plan, and I was involved in developing the Longitudinal Family Physician (LFP) Payment Model, so I've been quite immersed within Doctors of BC. Presidents-elect have often come from outside the organization, or certainly outside the Board, so they spend a lot of time learning initially. To some extent, I didn't have to spend the year learning in that way, so I could ensure I was present at the Board as a contributing director.

The biggest opportunity I had was to be more exposed to physician wellness and the current physician wellness crisis. We know that when students enter medicine, they have better psychological health than their peers. And yet, by the end of their residency, they're quite unwell. We're all suffering.

One thing that struck a chord with me, having grown up in Britain and worked there for something like 15 years, is the concept of institutional professionalism—the desire to conform to and assimilate into our career and present ourselves in a certain way, with our white coats. You certainly wouldn't show your tattoos or piercings or the other side of who you may be.

By attending various physician wellness events and some rural events, and through some of the truth and reconciliation work we did as we formed the Guiding Circle at Doctors of BC, I learned the commonality in need and purpose from these various spaces—that it's about who we are as *people* that connects us and allows us to have the difficult conversations. I also learned that I quite enjoy sound baths and floor yoga. Who knew!

I want to be seen as the same person in leadership as at home, in the office, and so on. Let's get rid of the hierarchy, assimilation, and conformity that our profession sometimes demands of us. I think physicians do extraordinary things, but they've also got families, they've got vulnerabilities, and they've got stressors, and the more we can connect with each other as *people* first, the better able we'll be to support one another in this profession.

I get great pleasure out my job as a family doctor through the connections I have with my patients. Connecting is the secret sauce of the work we do as physicians, and it's what I think we need to do as leaders.

I want to touch on the LFP Payment Model. I am not a family physician, but from what I have heard and read, by many accounts, it's been very well received. I think it has also struck up conversations across the country about how family physicians are remunerated. I've heard from many family physicians who have corresponded with the *BCMJ* that this has brought a boost of optimism to what could arguably be described as a bleak situation for many doctors, especially family doctors. What do you see on the horizon that might provide some light, some optimism for family doctors or BC physicians in general, who are struggling with workload, low morale, or burnout?

That's a difficult question, because we are in difficult times.

It's worth remembering that the payment model came from patient pressure on the government and political pressure from the government. I'd love to big-up the fact that as medical leaders at Doctors of BC we were being phenomenal advocates and did a great job, but in reality it was political pressure on the government, patients on the legislature lawn—acknowledging that BC Family Doctors and BC College of Family Physicians leaders may have supported that. Doctors of BC, by cultivating a collaborative relationship with the government over the years, was in a place where the government could come to us for help and support to develop that payment model. I hope the government remembers that the intent was to stave off a forthcoming crisis, more so than to reform and improve primary care. We have an eye on that, and there's still a pathway to improve primary care further than the LFP Payment Model has already—if the government works with us appropriately, and if the government uses the levers appropriately to drive the issues it wants. We devised the model with the intent to improve attachment, to improve access.

We are facing a difficult time—it's no secret that the government is billions of dollars in deficit, that we have significant reviews going on in the health care system, where the government is looking for financial reforms. One thing I look to with positivity is that when we hit periods of change like I think we're going to hit, it always brings opportunity. We've got to be alive to the potential to revamp and reform the health care system. We have phenomenal staff at Doctors of BC, incredibly thoughtful and dedicated to the work they do. We have some great leaders too. The light for me is maintaining Doctors of BC in the space where we can work with the government to try to help it solve problems moving forward. There are fires all over the province. We've seen a number of challenges of physicians struggling to provide services. I think there are challenging times ahead, unfortunately. The light that I see is in the power we have to connect with each other, band together, support each other, and seek opportunities as they arise.

Through the LFP Payment Model, we did something for primary care, and we've been battling ever since to do something for specialist care. We've struggled to get the traction we need to improve that situation. I've seen the pressure of wait lists and the

> **Let's get rid of the hierarchy, assimilation, and conformity that our profession sometimes demands of us.**

pressure of not having team-based care to support specialists in their work by working alongside a consultant dermatologist in my office. I know this from other leaders in the specialist space as well, and we've got to maintain the strength of being together to advocate, to effect the change.

There is still a major shortage of family physicians in BC, and there are a number of initiatives aimed at trying to get more medical students to choose family practice—we have the SFU School of Medicine starting to accept students in 2026. And your son is potentially heading toward a career in medicine. What would you say to inspire him to choose family practice in this environment? If my son chooses a career in medicine, I'll support him in whichever direction he chooses. I have a suspicion that, if anything, he'll try to become a neurologist.

We need more of literally every specialty across medicine. That's the bottom line. As an example, as a family doc, I cannot get dermatology care on the island, as our dermatologist is leaving. I've got to do virtual contacts or rely on the RACE line or send people to Vancouver. We need physicians across all disciplines.

There *are* opportunities, though. We're right to try to recruit from the US. I'm currently in dialogue with one US physician looking to move to a different system and perhaps somewhere they feel more culturally aligned.

I was speaking with a friend's son who is now a doctor about to graduate residency in the UK, and they can't get jobs over there because of the way the system is being funded. So there's an opportunity to bring over more UK grads as well.

To inspire anybody into medicine is to talk not only about the intellectual stimulation, but also about the value you get from delivering care well and the satisfaction of improving somebody's life as a result.

When I was a young doctor starting out in primary care in England, we used to do an on-call system where two docs would be on in the evening with a couple of nurses, for a population of about 200 000, and we'd sit around in the evening chatting and drinking coffee to keep us up. I was chatting with one doc, and I vividly remember him saying, "Adam, in general practice, we sort of nudge things along a bit, but ultimately, we don't often change the medical path of what's happening to the patient. They're still going to experience illness. Our job is to make them as content and as happy as possible along the journey."

That stuck with me as the important part of being a family doctor—being there as the advocate, being there to support patients. It's about the privilege of being in a position to care, to look after someone, and to make their health a bit better on that journey.

You took on a leadership role early in your career, as a resident; there have probably been some highs and some lows in your evolution. Tell me about that journey.

First, I'm not an academic leader, and I haven't done any of the big leadership courses. I am a completely experiential learner, both from other leaders, spaces, sources, and observations, and from having deep, rich conversations with people. There is something innate in the makeup of all medical leaders that keeps driving us. I think the work I've done and the journey I've had in leadership shows you don't necessarily have to rely on that academic side to progress.

My first leadership experience was in residency. I was doing a 1 in 4 on-call in the UK; we would start at 9 a.m. on Saturday and finish at 5 p.m. on Monday, and there were two juniors. We split the Saturday and Sunday nights and had 4 hours' sleep each. One of us had noon until 4, and the other had 4 until late. Other than that, we just worked solidly. We were getting half pay while doing that, which was mildly insulting.

I am a completely experiential learner, both from other leaders, spaces, sources, and observations, and from having deep, rich conversations with people.

It was clear we had a case to make as a group of physicians that we should be getting full pay for the hours we were working. To me, it was basic justice, to be honest, which is a crucial leadership value for me.

So, I corralled my colleagues, we filled out some time-management diaries, and I presented the case to the British Medical Association rep and the hospital board and said, "You owe us money." They ended up paying us, and that was my first experience in leadership.

Probably 5 or so years later, I was working in my hometown of Worcester, and the government tried to introduce private providers into the primary care space in the National Health Service (NHS) through a commissioning process.

Our city was to be one of the places where they would put out a tender for a new model of primary care. All the clinics and doctors were up in arms, ready to wave placards, saying, "This is terrible; how can you bring in private care?" Ironically, as independent practitioners, we were all private anyway, but on a much smaller basis than any of the big companies looking to come in.

We had a meeting with about 100 doctors, and everyone was talking about how to protest, how to resist, and I stood up and said, "We can protest all we like, and we'll feel better for it in the short term, but we can't change this coming, so why don't we think about how we can get together as a group of doctors, build something that would enable us to bid for this, and see whether we can harness it for the good of us all and our community?"

I sat down, expecting people to say either "You stupid idiot" or maybe "That's an idea; okay, we'll take that forward." Instead, the senior heads in the room went quiet, and then one of them stood up and said, "That's a good idea, Adam. Can you get on and do that, then, please?"

I was rougher around the edges back then, but I got on with it. I learned a lot from my brother-in-law at the time, who was a tax/corporate lawyer. He and I would sit at football matches and talk about legal structures. From that I built a limited company, and I persuaded 64 other family doctors to invest in the vehicle we built. I worked collaboratively with one of the local health authority provider trusts to build a bid and a tender. It was ridiculous; I was working 16-hour days, 7 days a week, for 4 or 5 months—full-time primary care and the rest of my time writing up this tender and this bid. But we won the contract.

We started to provide the service, and it did really well. The community received it well, and primary care physicians were happy that it was in our control, so there was no resistance from local clinics.

But the UK NHS changes its politics every 5 minutes, and it wanted to do something different again. At the time, I was less able to manage my frustrations around how it was changing. This is a skill I've since learned—understanding and holding on to the pragmatic reality that things change and you have to adapt.

I wanted to step away from leadership, maybe for a period of reflection, and then other things transpired in our lives, and we decided that we wanted to move somewhere where we could grow as a family—we didn't feel a strong connection to the UK. I vowed when we moved here that I wouldn't get involved in medical leadership again, because I felt a bit burned from it.

As part of moving here, I had to do exams in the UK, LMCC I, LMCC II, and all the rest of it, along with getting to know the system and re-upskilling in hospital care. But my next-door neighbor was vice chair of the Comox Valley Division of Family Practice, and as happens in small communities, he had us over for a meal and a chat, and I told him about my leadership work, and he said, "Oh, you should really apply for the Board."

I looked into it and applied, and when he stepped away from being vice chair, someone said, "Well, you really ought to be vice chair." I said, "Oh, okay." And eventually the chair stepped away, and someone said, "You really ought to be chair." And so I was back into leadership. The great thing about being in the division, as opposed to my role in the UK, is that our division was very well set up, and I worked closely with our executive director—somebody I learned from, Janet Brydon, a wonderful person.

She and I decided to go to town trying to get a primary care network (PCN) up and running, working alongside Dermot Kelly—who was an Island Health executive at the time but is now president and CEO of Fraser Health; we positioned Comox to be one of the first five in the province. We worked collaboratively with other PCNs and Dr Charlene Lui, who was in Burnaby at the time. We had a number of meetings of those five divisions. We had meetings with the ministry. We put heart and soul into trying to drive this to a place of success. There was a real opportunity to

> **One thing I look to with positivity is that when we hit periods of change like I think we're going to hit, it always brings opportunity. We've got to be alive to the potential to revamp and reform the health care system.**

support family medicine with better team-based care and provide an environment that would better support physicians, as well as provide for attachment and provide for a community I chose to live in. As an immigrant, I have a great sense of wanting to pay back the community.

Unfortunately, what the ministry decided the PCN was going to look like was nothing like what many of our divisions wanted it to look like. It was a cookie-cutter approach, a health authority–dominated model without any of the things we wanted to develop—embedding it into the community of physicians, having strong community ownership, having the flexibility that physicians needed, and most importantly having physician leadership. Physicians know what their communities need, and this model didn't provide that. When we had the opportunity to speak with [Adrian] Dix, health minister at the time, I raised my concerns about the PCN model, which led to him ordering a PCN refresh process with the support of the Family Practice Services Committee.

Frustration, irritation, and perhaps a bit of burnout from working hard to achieve something and having the result not be quite what I envisioned made me think about seeking an exit strategy and encouraging someone else to take on the role. After I slowly slipped out, I thought that might be the end of my leadership career.

Then, a division of family practice colleague of mine on the Island, who was on the Representative Assembly, encouraged me to run for a Board director position at Doctors of BC.

I thought about it, and one of the things I was concerned about through the PCN process was the way Doctors at BC was advocating for physicians with the government. I wanted to understand why we'd landed on a model that physicians didn't want—not what Doctors of BC's culpability was on that, but what was going on with our advocacy that had partly led to that.

I've come to learn that the Ministry of Health has the legislative pen, it holds the budget, and if the ministry wants to legislate, it can. We're seeing this in Quebec and Alberta. But how can we better advocate to ensure we have a system that physicians want to work in and feel comfortable working in? Because when we're all right, our patients are all right.

Shortly after I joined the Doctors of BC Board, we were hit with the pandemic, which led to major stress for the profession and for the Board. Frankly, we became a little divided around a senior leadership issue, which made it an even more challenging time. In the end, the Board decided to shift senior leadership within the organization, which was a difficult decision, but I believe it was the right one, and I think we've borne that out. I was then encouraged by a section of the Board to become chair, and as chair, I recognized that we needed to better connect physician leadership within and outside of Doctors of BC, because for far too long, we operated in silos. And when we're in silos, we're at higher risk of squabbling or being competitive. Physicians *are* competitive; that's the bottom line, but we need to apply it to achieve something *together*.

Because I wanted to build things back together, I designed a Board retreat away from our usual space, and we brought in the Joint Collaborative Committees co-chairs, to come together with human connection, and also kick off the beginning of the strategic plan, and we built the idea of regular Better Together meetings. We've maintained that group and added the societies, and I think it will evolve over time.

And of course, the opportunity for the LFP Payment Model came up, and it was an honor to work alongside four other great leaders: Dr Ramneek Dosanjh, who was Doctors of BC president at the time; Dr Joshua Greggain, who was president-elect and connected well to rural; Dr Maryam Zeineddin at BC Family Doctors; and Dr Renee Fernandez at BC Family Doctors.

Dr Fernandez and I co-led the process of negotiating to deliver something for our primary care colleagues. Doctors of BC, and the Board in particular, have worked hard ever since to try to deliver something for specialist care colleagues, particularly around the wait list initiative, which we've been working on since 2023. For whatever reason, the government isn't yet acting on our advocacy alongside Consultant Specialists of BC. It is an issue we need to continue highlighting.

It's through visibility and understanding that we drive reconciliation.

Fairness and equity are important values to you, and Doctors of BC has been a leader in its strategic plan and in committing to improvements in cultural safety, anti-racism, and Indigenous-led initiatives. What does that mean for your presidency, for physicians, and for equity-deserving patients in BC?

We have stood up our Guiding Circle at Doctors of BC, and as president, that's something I will be a part of. We want our Indigenous colleagues and partners, both physicians and nonphysicians, to be very visible. It's through visibility and understanding that we drive reconciliation. I believe that truth and reconciliation must ensure that *all* truths are heard to get to a point of reconciliation. Sitting down in guiding circles and understanding each other's perspectives will be key in the next year. I want to see how we drive our Guiding Circle to help inform Doctors of BC across the organization and across policies, not only valuing and uplifting Indigenous communities and the care of Indigenous patients and supporting Indigenous physicians in their work, but also bringing aspects of Indigenous culture into the work we do. When I sit with Indigenous friends, or in something like the Guiding Circle, it's always led with "Who are you as a person?" We can learn a lot from Indigeneity about how to show up with each other. I want to reflect some of that this year, and I want to make our Guiding Circle more visible to members. I also want our members' truths about how they feel about truth and reconciliation to be heard, because there's a diversity of views, and we need more than a unipolar approach. We have to understand how everybody is feeling to get to points of reconciliation.

When I was Board chair, we also stood up the IDEA (Inclusion, Diversity, and Equity Advisory) Committee to look at how we could do better in terms of EDI, both within Doctors of BC and within the profession. For instance, I still see a significant gender imbalance in medicine. Dr Dosanjh was recently appointed executive vice president, North America, for the Medical Women's International Association. It's exactly the space that she will be excellent in—tenacious and fearless—and maintaining connections such as this as president will enable me to better understand some of the gender imbalances that we experience.

If we go back to the principle of showing up as people first, people are diverse, and we need to ensure everybody feels comfortable showing up as who they are. Otherwise, we're not tapping into the full talents of humanity. I'm cognizant that I am a white, middle-aged male, growing up through a patriarchal profession, and that my own projections of who I am could be offensive to some people, particularly with my stern British accent and stiff upper lip and all that. I hope that trying to lead as a human first will ensure that people see that we're all in it together.

You have a lot of great ideas and experiences to help inform your goals for the year ahead. Are there any other causes you're interested in pursuing that we haven't touched on yet?

I'm very keen to advocate that we have a responsibility to do something about climate change. As physicians, our role is to care for society and the community, and I believe one of the biggest threats to society and communities is climate change. We have a responsibility to try to offer leadership in that space.

When your presidency is finished, what would be a mark of success for you in this role?

My role is to be a representative of the profession—the spokesperson for the organization and potentially the spokesperson for physicians. The Board's role is to set the direction for how Doctors of BC functions and its policies and strategy. That's important to remember.

I hope people see me as having demonstrated an ability to fight for them, but in a compassionate way. If I can persuade physicians that it's okay to show up as they are, rather than feeling they have to put on the armor of a white coat and assimilate, then I will feel that I have achieved something. I also want to focus on ensuring that we see leaders as just other humans doing the job alongside our colleagues. ■

RSV immunization in older adults

Three vaccines have been authorized by Health Canada for the prevention of severe respiratory syncytial virus disease in older adults. These vaccines have demonstrated effectiveness in reducing hospitalizations and other serious outcomes.

Jia Hu, MD, MSc, CCFP, FRCPC, Julene Cranch, RN, MPH

Background

Respiratory syncytial virus (RSV) is a common seasonal respiratory virus. Alongside influenza and SARS-CoV-2, it is a leading cause of severe respiratory infections in both adults and infants, although this review will focus on RSV in adults. The risk of severe outcomes, including hospitalization and death, increases with both age and comorbidities. An Ontario study on the burden of RSV showed the incidence of hospitalization was 2.0 per 100 000 for those 18–49 years of age, compared with 134.7 per 100 000 for those 80 years of age or older and 370.9 per 100 000 for transplant recipients.[1] A systematic review of the burden of RSV in Canada showed that the case fatality rate among adults hospitalized for RSV ranged from 5% to 10% and suggested that the overall burden of RSV among older adults could be close to that of influenza.[2] Immunization can offer significant protection for adults against severe outcomes from RSV.

Immunization options for prevention of RSV

Three vaccines are currently authorized by Health Canada for the prevention of RSV in older adults:

- RSVpreF (Abrysvo, manufactured by Pfizer Canada ULC) is an unadjuvanted, protein subunit vaccine authorized for the prevention of lower respiratory tract disease caused by RSV in adults 60 years of age and older and in adults 18–59 years of age at increased risk of RSV disease. RSVpreF can also be used in pregnancy to confer infant protection, but this indication is beyond the scope of this review.
- RSVPreF3 (Arexvy, manufactured by GSK Canada) is an adjuvanted protein subunit vaccine authorized for the prevention of lower respiratory tract disease caused by RSV in adults 60 years of age and older and in adults 50–59 years of age at increased risk of RSV disease.
- mRNA-1345 (mResvia, manufactured by Moderna, Inc.) is an mRNA vaccine authorized for the prevention of lower respiratory tract disease caused by RSV in adults 60 years of age and older. As of December 2025, mRNA-1345 was not available in Canada but was expected to be available shortly.

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This article is the opinion of the BC Centre for Disease Control and has not been peer reviewed by the BCMJ *Editorial Board.*

*This article is a continuation in a series on RSV. "RSV immunization in pregnancy and infancy" was published in December 2025 [*BCMJ *2025;67:348-353].*—Ed.

Key points

- Three vaccines have been authorized by Health Canada to prevent respiratory syncytial virus (RSV) infection in older adults; two (RSVpreF and RSVPreF3) are currently available in British Columbia. The National Advisory Committee on Immunization (NACI) strongly recommends that adults 60 years of age and older living in nursing homes or chronic care facilities and all adults 75 years of age and older receive the RSV vaccine. The NACI further recommends that adults 50–74 years of age consider the RSV vaccine in consultation with their health care provider.
- RSVpreF and RSVPreF3 are both given as a one-time dose. They can reduce the risk of RSV-associated hospitalization by almost 80% and offer protection for a minimum of 2 to 3 years. Boosters and subsequent doses are not currently recommended, as their benefit has not yet been elucidated.
- RSVpreF and RSVPreF3 are widely available in pharmacies at a cost of $250–$300 per dose. BC does not currently publicly fund RSV vaccines for older adults, but some private insurance plans may cover the cost.

Further information on RSVpreF and RSVPreF3, including detailed administration instructions, product components, and contraindications, can be found on the Abrysvo and Arexvy biological product pages.[3,4]

National Advisory Committee on Immunization recommendations on RSV immunization in older adults

The National Advisory Committee on Immunization (NACI) has released two statements on the use of RSV vaccines in older adults. The first statement was released in July 2024, reflecting the authorization of two vaccines, RSVpreF and RSVPreF3, while the second statement was released in March 2025, reflecting changes in the age authorization for RSVPreF3 and the authorization of a new RSV vaccine, mRNA-1345.[5,6] NACI makes two types of recommendations. Strong recommendations apply to most populations and should be followed, while discretionary recommendations could be considered, but alternative approaches are reasonable. NACI recommendations for RSV immunization in older adults are as follows:

- Strong recommendation: NACI recommends RSV immunization programs for adults 75 years of age and older, particularly older adults at increased risk of severe RSV disease **[Box]**.
- Strong recommendation: NACI recommends RSV immunization programs for adults 60 years of age and older who are residents of nursing homes or other chronic care facilities.
- Discretionary recommendation: NACI recommends that RSV vaccines be considered as an individual decision by adults 50–74 years of age in consultation with their health care provider.

NACI recommends that any of the three vaccines authorized by Health Canada can be used—in other words, there is no preferential recommendation for any of the vaccines at a population level. However, NACI does articulate that because there is less available data for the safety and efficacy of mRNA-1345 compared with the protein subunit vaccines, and from a programmatic perspective, mRNA-1345 may be less cost-effective due to potentially lower vaccine efficacy.

A Canadian study on RSVpreF and RSVPreF3 showed that immunizing adults over 70 years of age who have chronic medical conditions and all adults over 80 years of age would be cost-effective using a $50 000 per quality-adjusted life year threshold, which is broadly in line with NACI's recommendations.[7]

BOX. Clinically significant chronic health conditions for which RSV vaccination is particularly important.

- Cardiac and pulmonary disorders, including chronic obstructive pulmonary disease, asthma, cystic fibrosis, and conditions affecting the ability to clear airway secretions.
- Diabetes mellitus and other metabolic diseases.
- Moderate and severe immunodeficiency.
- Chronic renal disease.
- Chronic liver disease.
- Neurological or neurodevelopmental conditions, including neuromuscular conditions, neurovascular conditions, neurodegenerative conditions (e.g., dementia), and seizure disorders, but excluding migraines and psychiatric conditions in the absence of neurological conditions.
- Class 3 obesity (defined as having a BMI of 40 kg/m^2 or over).

Dose schedule, timing, and boosters

All three vaccines authorized by Health Canada are administered as a one-time, intramuscular dose. RSV-immunizing products are optimally administered just before the start of the RSV season, which typically occurs in the early fall.[8] RSV vaccines can be administered concomitantly or at any time before or after the administration of other non-live vaccines, although consideration can be given to administering RSV vaccines at least 6 weeks before or after non-seasonal vaccines (e.g., the shingles vaccine) to better attribute any reported adverse events.[6]

There is currently a lack of evidence on whether the response to RSV vaccines can be boosted through subsequent doses. For example, a phase 3 RCT of RSVPreF3 reported that revaccination 1 year following initial immunization (i.e., two doses of RSVPreF3 received) resulted in three-season vaccine efficacy in the same range as those that were not revaccinated (i.e., only one dose of RSVPreF3 received).[9]

A study involving RSVpreF showed that revaccination after 12 months increased antibody levels, but they remained at lower levels than observed after the first dose. A study involving mRNA-1345 showed that revaccination after 12 months increased antibody levels to those observed after the first dose.[6] Due to the uncertainty of the effectiveness of booster doses, NACI does not currently recommend booster doses for RSV, although this is an area of emerging research.[6]

Vaccine efficacy

Vaccine efficacy reported in RCTs among adults 60 years of age and older against manufacturer-defined endpoints of RSV-related lower respiratory tract disease over two seasons was 59% for RSVpreF and 67% for RSVPreF3, with waning observed for both vaccines.[10,11]

Vaccine efficacy for RSVpreF declined from 65% to 56% between season one and two, while vaccine efficacy for RSVPreF3 declined from 83% to 56% between season one and two. Additionally, one study demonstrated that RSVPreF3 offered protection into the third season, although vaccine efficacy declined even further to 48%.[9] For mRNA-1345, vaccine efficacy among adults 60 years of age and older was estimated to be 59%.[6,12] Real-world studies have also demonstrated the effectiveness of protein subunit vaccines. A recent review article on the effectiveness of RSVpreF and RSVPReF3 showed a pooled vaccine effectiveness of 79% against hospitalization using three case-control studies and effectiveness of 70% to 73% among immunocompromised adults,[13] indicating

the vaccines confer significant protection against hospitalization.

Vaccine side effects, precautions, and contraindications

In general, RSV vaccines have good safety profiles. The vast majority of reported adverse events are mild to moderate in nature, and very few severe adverse events have been reported.[12,14,15] Local and systemic adverse events were more common among those receiving RSVPreF3 or mRNA-1345 than those receiving RSVpreF.[6] The most common local adverse event was injection site pain, while the most common systemic adverse events were fatigue and headache.

Post-marketing surveillance data indicate that there may be a small but elevated risk of Guillain-Barré Syndrome following administration of protein subunit vaccines (RSVpreF and RSVPreF3), on the order of 1.8 to 4.4 cases of Guillain-Barré Syndrome per million doses of vaccine administered.[16] The only contraindication to RSV vaccines is a history of anaphylaxis to a previous dose of the RSV vaccine or any component of the vaccine.

Accessing RSV vaccines in British Columbia

British Columbia does not currently offer publicly funded RSV vaccines for older adults. While NACI makes clinical and public health recommendations for a vaccine's use, it is up to individual provinces and territories to make funding decisions for vaccines. Public funding for an older adult RSV vaccine program continues to be assessed based on clinical impact, cost, and cost-effectiveness.

RSVpreF and RSVPreF3 are widely available in pharmacies across British Columbia; no prescription is required. The vaccines are priced at $250 to $300 per dose. Although there is no public funding for RSV vaccines for older adults, patients may have private insurance that will offset the cost of the vaccines. The BC Pharmacy Association has a tracker that allows individuals to search for pharmacies with RSV vaccines (www.bcpharmacy.ca/rsv-vaccines).[17]

Other relevant links and references

Some useful links, references, and guidelines are available from NACI, BCCDC, and the BC Pharmacy Association:

- **NACI:** *Updated Guidance on Respiratory Syncytial Virus (RSV) Vaccines for Older Adults Including the Expanded Use of RSVPreF3 for Individuals 50–59 Years of Age and Use of the New mRNA-1345 Vaccine* (www.canada.ca/en/public-health/services/publications/vaccines-immunization/national-advisory-committee-immunization-statement-updated-guidance-rsv-vaccines-older-adults-including-expanded-use-rsvpref3-individuals-50-59-years-age-use-new-mrna-1345-vaccine.html).
- **BCCDC:** Abrysvo (RSVpreF) biological product page (www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part4/RSV_Abrysvo.pdf).
- **BCCDC:** Arexvy (RSVPreF3) biological product page (www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/Part4/RSV_Arexvy.pdf).
- **BC Pharmacy Association:** *Respiratory Syncytial Virus (RSV) Vaccines in Pharmacies* (www.bcpharmacy.ca/rsv-vaccines).

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Rural data amplification: Linking the needs of rural population catchments to health services in British Columbia

Rural health data can be more effectively organized through the use of population catchments to facilitate needs-based planning and serve as a framework for research and quality improvement initiatives.

Sarah Kelly, BA, Theresa (Asha) Dunn, BSc, Esther Kim, MPH, Stefan Grzybowski, MD

There has been a steady and progressive decline in support for rural health care across Canada, including in British Columbia, where many barriers have not been adequately addressed, including those related to patient transportation, scope of rural facility services, ratio of physicians to population, burnout among health care providers, and lack of adequate financial and social resources.[1-5] It is also generally recognized that research on rural health care "is limited, poorly funded, and not well coordinated, and it often fails to be used in informing health policy."[1] The subsequent lack of valid rural-specific data makes it difficult to sustain appropriate and sustainable levels of rural health services in a rural generalist context.[6] Nonetheless, government resources, policies, and infrastructure continue to prioritize urban perspectives, with rural priorities falling to the wayside. To address the need for more effective rural health data organization, we propose the use of a needs-based catchment approach designed specifically for the rural context, which provides clarity and accountability and serves as a framework for quality improvement and research.

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Existing geographic health boundaries

The emphasis on urban-centred policies can be seen clearly in the existing health-related data in Canada, which prioritizes a use-based reporting structure and access to specialist services—factors that do not reflect the reality of rural generalist health systems and service use.[4] Currently in BC, health data are organized across the province using nested geographic health boundaries aligned with regional health authorities. There are four levels of data stratification, with health authorities being the broadest health boundary. Each health authority is divided into health service delivery areas, which are further subdivided into multiple local health areas. Each local health area comprises one or more community health service areas.[7] Community health profiles, which compile demographic and health data, have been created for 195 community health service areas and 142 municipalities across the province.[8] While this provides a consistent approach across the province, there are significant limitations to their application in rural areas.

Community health service areas must cover the entire province, which means that they are often very large in rural areas and contain significant areas of unpopulated land and/or regions with low population density. Moreover, the boundaries of these areas do not always align with the natural catchments of rural communities. This limits the utility of these areas as geographic units for reporting rural health data, as there is a lack of linkage between health service facilities and the surrounding populations that naturally depend on each facility. Further, the specialist-oriented data that are predominant in the community health profiles, such as reports on the number of patients with renal failure or myocardial infarctions, limit the utility of community health service area data in a rural context, where generalist care is more common and generalist care measures are needed.[4,8]

Catchments as a complementary approach

We propose a complementary geographic approach to structuring rural health data, through population catchments. Broadly, a population catchment is the geographic

area around a service point defined using criteria such as travel time or distance. The catchment population is then defined by the number of people living within that geographic area. Researchers have developed similar population catchments in other parts of the world, such as rural and remote Australia[9] and sub-Saharan Africa,[10] with similar objectives to increase the utility of rural health data and improve equity in services. We propose a population catchment approach for BC based on drive time to a given health care facility (in this case, rural hospitals). BC's mountainous and coastal terrain lends itself to this catchment approach, as communities tend to be naturally separated from one another, making it clear which health facility rural residents are most likely to seek out. We intend this structure to be complementary to the overarching Ministry of Health geographic health boundaries that are mentioned above. To start, we have developed catchments based on a 1-hour drive time to a facility for all rural communities that contain a hospital and have a catchment population under 25 000 **[Figure 1]**. Catchments were created using ArcGIS Pro, and population estimates were derived from Canadian census data.

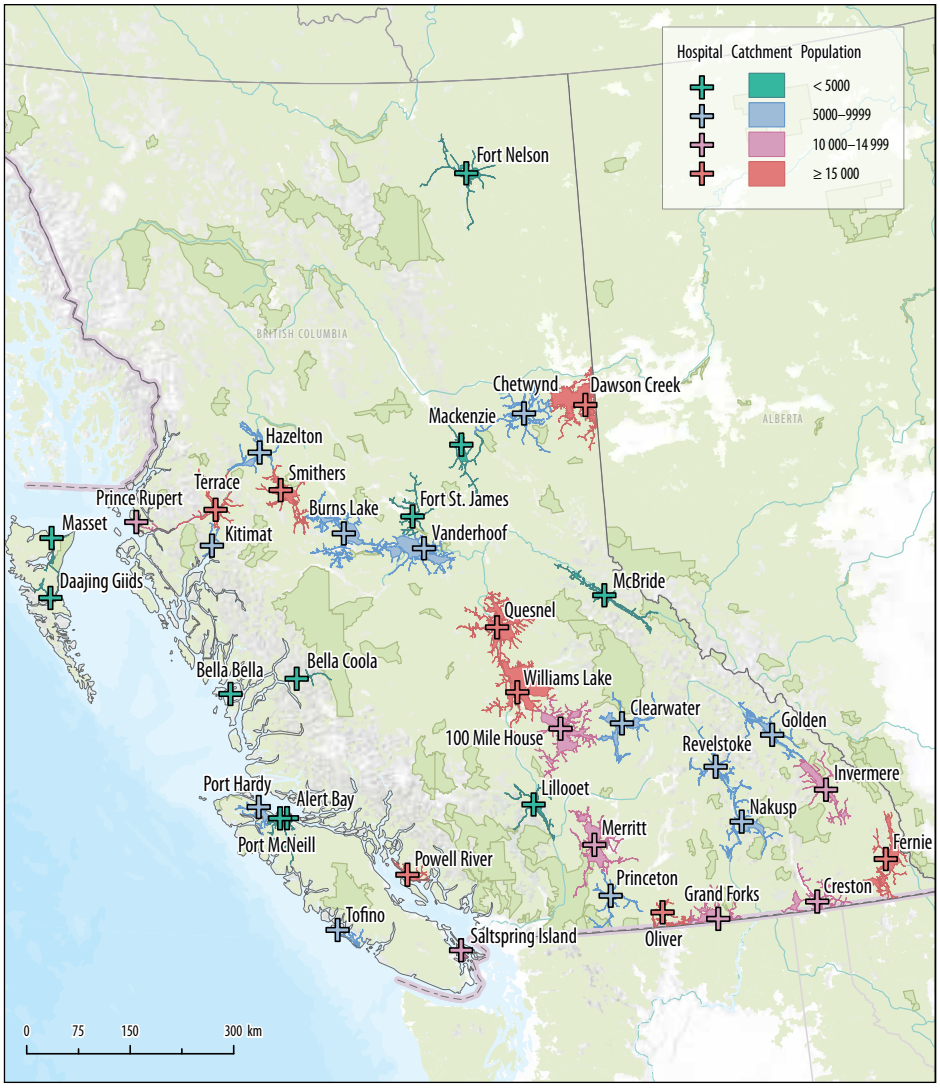

FIGURE 1. Map of all rural hospital catchments in BC for communities with a population under 25 000.

Advantages of catchments for rural communities

The goals of the population catchment approach are to build on the geographic characteristics of rural communities in BC and to define populations that naturally depend on local hospitals and associated services. Moreover, data that are structured on a catchment framework will provide a reasonably informed denominator for the catchment of a defined service facility, which will help facilitate improved needs-based planning accountability and quality improvement initiatives. A needs-based approach to health services planning, as opposed to one that is based on use, is better suited for rural communities because it allows health care systems to dynamically adapt to changes in population needs as they arise in the community.[11] Similarly, when health services do not prioritize population needs in the planning process, unmet needs may go unnoticed until they worsen and create greater undue stress for patients and the health care system as a whole.

Being able to define the catchment for a specific health facility also sets the stage for research examining the system's efficacy and effectiveness. To this point, we have developed two needs-based measures and applied them to our rural catchments: the Rural Birth Index (RBI) and the Rural Generalist Provider Services Index (RGPSI). The RBI serves as an objective measure of population needs for birthing services, including surgical services,[12] and the RGPSI aims to quantify the need for rural generalist services at the community level. Demographic characteristics of the catchment can also be captured by combining the geographic catchment boundaries with other data sets, such as Canadian census data **[Figure 2]**. We compiled demographic data; our needs-based measures; and a variety of other information related to health services, referrals, transportation, and the environment into catchment profiles that can be used by rural health care providers, administrators, and community members. In this way, it is perhaps not unrealistic to imagine that through the transparency of understanding rural populations and the services that sustain them, we may have new ideas to apply across the larger health care system.

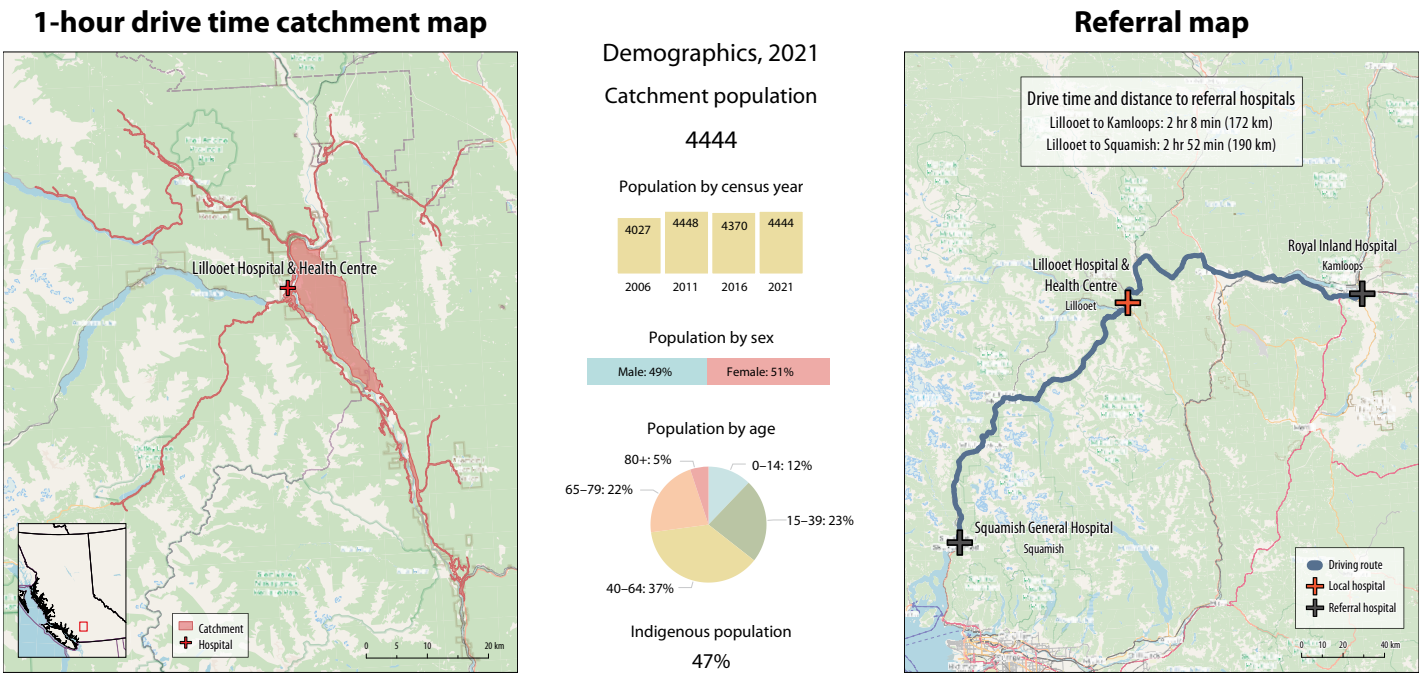

FIGURE 2. Catchment map, population demographics, and referral map for the Lillooet catchment.

Limitations

The principal limitation of our approach is that while it may work well for rural communities in a mountainous or coastal context, it loses focus as the population becomes more densely located and the terrain becomes more navigable. Therefore, we propose a population catchment approach specifically designed for rural communities of fewer than 25 000 people located in areas where communities have natural separation. While 1 hour is a reasonable amount of time to travel to a facility to receive care and provides a standard measure allowing for comparison between rural communities, it may not fully depict the realities of each community. Therefore, in addition to the standard 1-hour catchments, we are interested in expanding to create secondary catchments, tailored to specific communities.

Finally, because health service data are a moving target, it is challenging to constantly provide up-to-date data. To address this limitation, it is imperative that local providers have access to data related to their communities and that they have the ability to update these data on an ongoing basis.

Conclusions

Rural areas have the advantage of being able to naturally group the local population into distinct community catchments, which provides the opportunity to link the needs of the population with the services that can meet those needs, providing clarity, accountability, research opportunity, and a quality improvement framework. It is time we bring in the data infrastructure that is capable of serving the needs of rural communities. ■

Competing interests

None declared.

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Regional disparities in medical specialties in rural British Columbia

In 2022–23, only 6% to 7% of internal medicine specialists, pediatricians, and psychiatrists were registered in rural and remote areas, straining patients, family physicians, emergency services, and surgical specialties.

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ABSTRACT

Background: Health care disparities in rural and remote British Columbia have persisted over time despite efforts to improve access to care. While strategies have typically focused on improving access to primary care, discrepancies in access to specialist care remain uncertain. The aim of this study was to better understand the temporospatial distribution of general specialists in BC.

Methods: Clinician data were acquired from BC Ministry of Health Medical Services Plan reports for 2010–11 to 2022–23. The number of internal medicine specialists, pediatricians, and psychiatrists registered in each health service delivery area was analyzed over time.

Results: In 2022–23, 1480 internal medicine specialists, 364 pediatricians, and 864 psychiatrists were registered in BC. Only 6% to 7% of specialists were registered in rural and remote areas, a pattern that has persisted despite increases in clinician numbers since 2010–11.

Conclusions: Rural–urban discrepancies in specialist distribution in BC have persisted over the past decade. We call upon clinicians and policymakers to address this long-standing issue.

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Background

Health care disparities in rural and remote regions of British Columbia are well documented in the literature.[1,2] Despite efforts to close the gap, such as the creation of rural medical school training streams, health care inequities persist.[1,3,4] In recent decades, significant efforts have focused on addressing the shortage of primary care physicians in rural BC.[4,5] However, with advances in medicine, an aging population, and the increasing complexity of patients across the whole spectrum of age, specialists play a key role in the care of rural patients.[6]

Rural–urban health care inequities span medical fields, including internal medicine, pediatrics, and psychiatry. In BC, only 40 pediatricians live and practise in rural communities, and the vacancy rate for pediatrician postings in rural communities has been 25% to 30% for several years.[7,8] Northern BC continues to face challenges recruiting pediatricians, despite the population having the highest percentage of children of any region in the province. Rural communities also experience worse mental health outcomes and, in particular, disproportionately higher suicide rates than urban centres.[9,10] Individuals in rural communities experience additional unique mental health needs compared with people in urban centres due to economic hardship associated with living in resource-centred towns, privacy concerns in seeking psychiatric help in small communities, and lack of outreach services.[9,11] The situation is further complicated by the current opioid crisis, where BC has double the rate of opioid toxicity compared with the national average.[12] Additionally, rural patients often face complex logistical challenges and financial and psychological consequences when they have to travel long distances to seek specialist services that are unavailable in their community.[13] The lack of access to specialists also strains primary care providers, emergency services, and surgical

specialists such as obstetricians, who may feel that they need to practise outside their scope to address immediate patient needs.[2]

In recent years, innovative solutions to address health care needs have included the use of telemedicine and increasing outreach or mobile clinical services.[13,14] While some acute medical needs of BC's rural patients may be supported by Real-Time Virtual Support (RTVS) services, such as the recently established Rural Outreach in Critical Care and Internal Medicine (ROCCi) and Child Health Advice in Real-Time Electronically (CHARLiE) hotlines, many of their acute and chronic health care needs are not being met.[14,15] Fly-in/fly-out services, locums, and telehealth options attempt to support regions in need, but wait times can be significant, and long-term care can be affected. As a result, patients may receive suboptimal treatment of complex chronic medical diseases, which places further strain on the health care system. These strategies do not replace the need for having on-the-ground specialists in many of BC's larger rural communities.[9] In addition, rural specialists may face shortages of specialized equipment, support staff with enhanced training, and social services, which are needed to provide comprehensive services comparable to those in urban settings.[16]

Overall, access to specialists in rural BC is limited. The aim of this study was to better understand the temporospatial distribution of specialists in BC.

Methods

Physician data were acquired from BC Ministry of Health Medical Services Plan (MSP) reports for fiscal years 2010–11 to 2022–23.[17] Data were summarized for the following specialties because they represent some of the most common nonprocedural "general" specialists in rural communities: internal medicine, pediatrics, and psychiatry.

The number of specialists per 100 000 persons was calculated using MSP registrants as a proxy for population. Data were analyzed for each Health Service Delivery Area (HSDA). The following HSDAs were deemed rural regions: East Kootenay, Kootenay Boundary, North Vancouver Island, Northwest, Northern Interior, and Northeast. The BC Rural Practice Subsidiary Agreement considers all communities in these regions as rural based on the following criteria: number of designated specialties within 70 km, number of general practitioners within 35 km, community size, distance from major medical community, degree of latitude, specialist centre, and location arc.[18] Data for physicians with unknown locality were excluded. Maps displaying the distribution of physicians in HSDAs and changes over time were created by the authors using QGIS (v. 3.34).

In 2022–23, 6% of internal medicine specialists, 7% of pediatricians, and 6% of psychiatrists were practising in rural Health Service Delivery Areas.

The numbers of physicians registered as practising "internal medicine" and "general internal medicine" were combined and reported as "general internists." The number of physicians in the following internal medicine specialties were combined and reported as "subspecialists": geriatrics, cardiology, rheumatology, clinical immunology and allergy, respirology, endocrinology, critical care, gastroenterology, nephrology, infectious diseases, hematology, and oncology. General internists and subspecialists were collectively referred to as "internal medicine specialists." Subspecialists in psychiatry and pediatrics are not listed separately in the MSP register, so they were reported as "psychiatrists" and "pediatricians," respectively.

Results

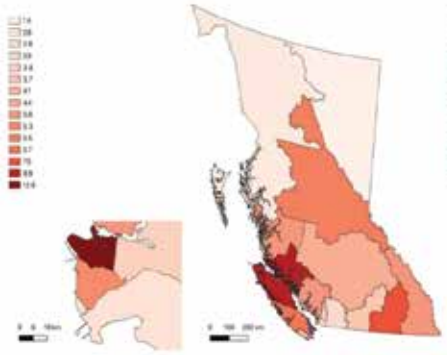
In 2022–23, 1480 internal medicine specialists (439 general internists), 364 pediatricians, and 864 psychiatrists were practising in BC. Of these, 6% of internal medicine specialists, 7% of pediatricians, and 6% of psychiatrists were practising in rural HSDAs.

Internal medicine

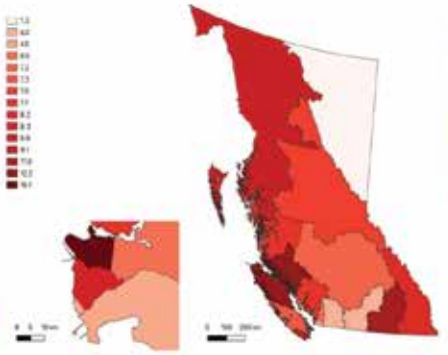
Urban regions had more internal medicine specialists per capita than rural regions, a situation that has persisted since 2010–11 [Supplementary Table 1A; supplementary materials are available from the corresponding author]. In 2022–23, Vancouver had 65.4 internal medicine specialists and 49.2 subspecialists per 100 000 persons, whereas the Northeast region had 1.3 internal medicine specialists per 100 000 persons and no subspecialists [Supplementary Table 2]. Provincial medians were 19.0 internal medicine specialists and 11.7 subspecialists per 100 000 persons.

From 2010–11 to 2022–23, there was a 69% increase in the number of internal medicine specialists across all regions, with urban areas experiencing the greatest increase [Supplementary Table 3; **Figure 1**]. The number of internal medicine specialists per capita increased in all HSDAs except the Northeast. The greatest increases per capita occurred in urban regions (an increase of 10.1 in Vancouver versus 3.7 in the East Kootenay region and 3.2 in the North Vancouver Island region).

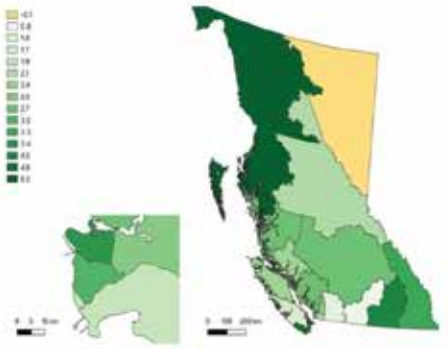
From 2010–11 to 2022–23, the number of general internists per capita increased in both urban and rural regions **[Figures 1 and 2]**. In 2022–23, general internists made up a greater proportion of internal medicine specialists in rural regions than in urban centres (100% in the Northeast and Northwest regions versus 25% in Vancouver); similar ratios occurred in 2010–11 **[Figure 1;** Supplementary Table 2**]**.



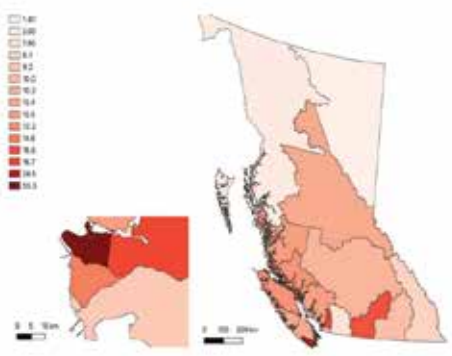
Number of general internists per 100 000 persons by Health Service Delivery Area in 2010–11.



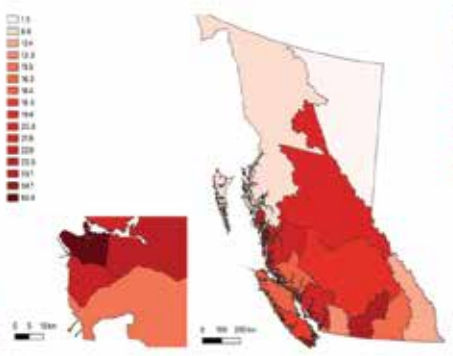
Number of general internists per 100 000 persons by Health Service Delivery Area in 2022–23.



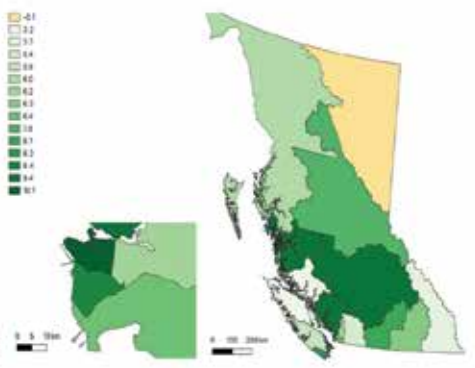
Change in the number of general internists per 100 000 persons by Health Service Delivery Area between 2010–11 and 2022–23.



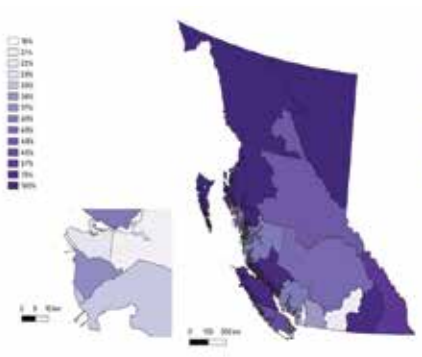
Number of internal medicine specialists per 100 000 persons by Health Service Delivery Area in 2010–11.



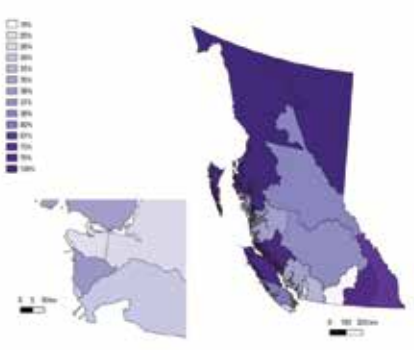
Number of internal medicine specialists per 100 000 persons by Health Service Delivery Area in 2022–23.



Change in the number of internal medicine specialists per 100 000 persons by Health Service Delivery Area between 2010–11 and 2022–23.



Proportion of internal medicine specialists who were general internists in 2010–11.



Proportion of internal medicine specialists who were general internists in 2022–23.

FIGURE 1. Distribution of and change in the number of general internists and internal medicine specialists across BC, between 2010–11 and 2022–23. Darker gradients of red represent higher physician density; lighter gradients of red represent lower physician density. Gradients of green represent increases in physician density; gradients of yellow represent decreases in physician density. Darker gradients of purple represent greater proportions of internal medicine specialists who were general internists; lighter gradients of purple represent smaller proportions. The inset maps show Vancouver and surrounding areas.

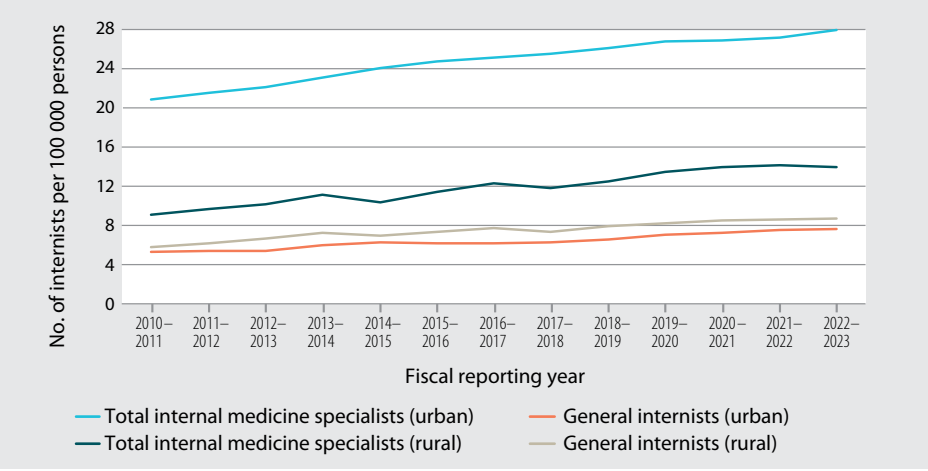
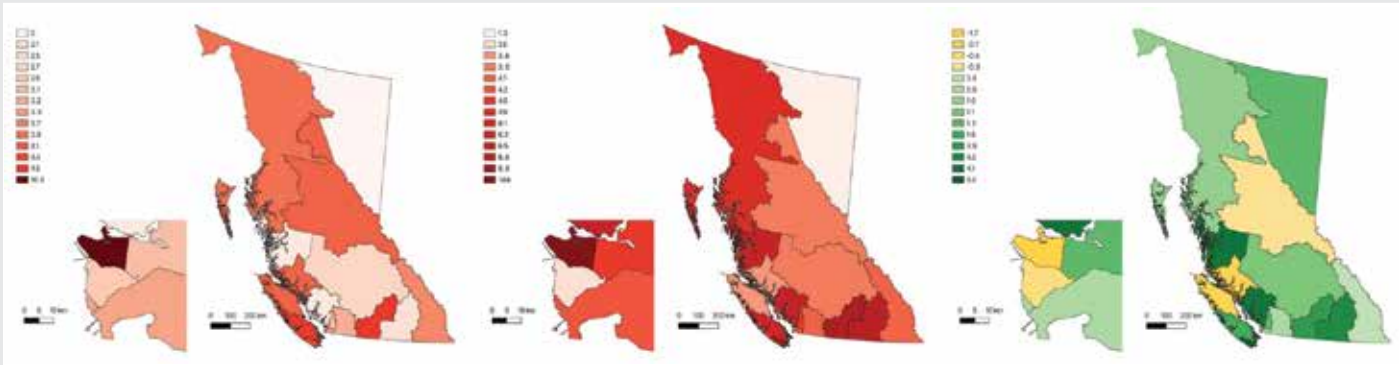


FIGURE 2. Number of internal medicine specialists and general internists per 100 000 persons in rural versus urban Health Service Delivery Areas over time.

In more rural areas, general internists made up a greater proportion of internal medicine specialists than subspecialists, which underscores the importance of rural generalism, a concept that is frequently discussed in primary care literature.



Number of pediatricians per 100 000 persons by Health Service Delivery Area in 2010–11.

Number of pediatricians per 100 000 persons by Health Service Delivery Area in 2022–23.

Change in the number of pediatricians per 100 000 persons by Health Service Delivery Area between 2010–11 and 2022–23.

FIGURE 3. Distribution of and change in the number of pediatricians across BC between 2010–11 and 2022–23. Darker gradients of red represent higher pediatrician density; lighter gradients of red represent lower pediatrician density. Gradients of green represent increases in pediatrician density; gradients of yellow represent decreases in pediatrician density. The inset maps show Vancouver and surrounding areas.

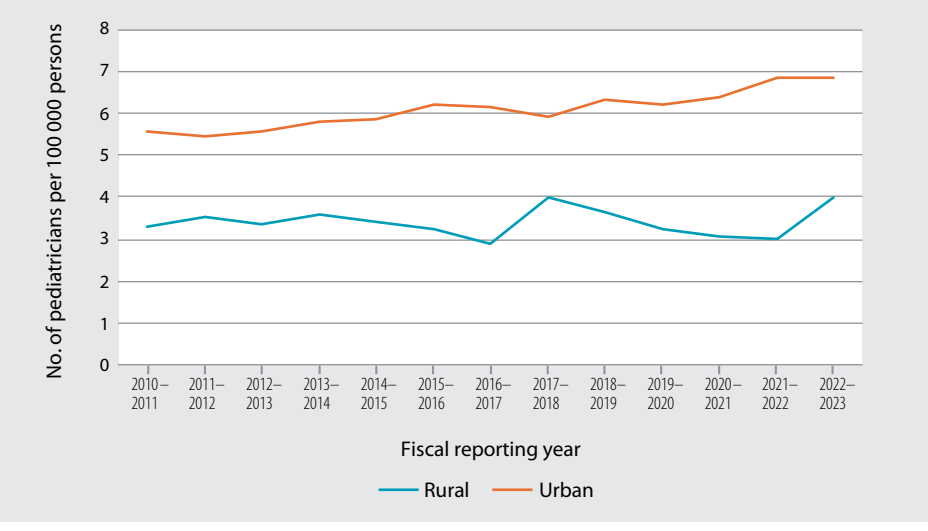


FIGURE 4. Number of pediatricians per 100 000 persons in rural versus urban Health Service Delivery Areas over time.

Pediatrics

Urban regions had more pediatricians per capita than rural regions, a situation that has persisted since 2010–11 [Supplementary Table 1b]. In 2022–23, Vancouver had 14.6 pediatricians per 100 000 persons, whereas the Northeast region had 1.3 pediatricians per 100 000 persons. The provincial median was 4.3 pediatricians per 100 000 persons.

From 2010–11 to 2022–23, there was a mixed trend in the number of pediatricians per capita across regions [Supplementary Table 3; **Figure 3**]. In 4 of the 16 HSDAs, the number of pediatricians per capita decreased, including in both rural and urban communities. Urban regions had a slightly greater increase in the number of pediatricians per capita than rural regions [**Figure 4**].

Number of psychiatrists per 100 000 persons by Health Service Delivery Area in 2010–11.

Number of psychiatrists per 100 000 persons by Health Service Delivery Area in 2022–23.

Change in the number of psychiatrists per 100 000 persons by Health Service Delivery Area between 2010–11 and 2022–23.

FIGURE 5. Distribution of and change in the number of psychiatrists across BC between 2010–11 and 2022–23. Darker gradients of red represent higher psychiatrist density; lighter gradients of red represent lower psychiatrist density. Gradients of green represent increases in psychiatrist density; gradients of yellow represent decreases in psychiatrist density. The inset maps show Vancouver and surrounding areas.

Psychiatry

Urban regions had more psychiatrists per capita than rural regions, a situation that has persisted since 2010–11 [Supplementary Table 1c; **Figure 5**]. In 2022–23, Vancouver had 43.1 psychiatrists per 100 000 persons, whereas the Northeast had 5.3 psychiatrists per 100 000 persons. The provincial median was 10.3 psychiatrists per 100 000 persons.

From 2010–11 to 2022–23, there was a mixed trend in the number of psychiatrists per capita across regions [Supplementary Table 3; **Figure 6**]. In 7 of the 16 HSDAs, the number of psychiatrists per capita decreased, including in both rural and urban communities. Overall, urban regions experienced no change in the number of psychiatrists per capita, whereas rural regions experienced an increase.

Discussion

During the study period, there was a disparity in specialist distribution across HSDAs in BC, with fewer specialists per capita in rural regions than in urban centres. This pattern remained constant between 2010–11 and 2022–23, despite absolute increases in the number of specialists. In certain HSDAs, a single specialist may be providing care within their specialty to an entire region; this can pose a serious risk of service disruption to entire geographic regions of BC. The loss of even a single specialist in rural regions can drastically reduce the per capita distribution of specialists in that area. Similarly, small gains in the number of specialists in rural regions translate to significant increases in the number of specialists per capita and access to specialty care. This highlights significant inequities in access to specialist care and the need to create programs that support the recruitment and retention of specialists in rural communities.

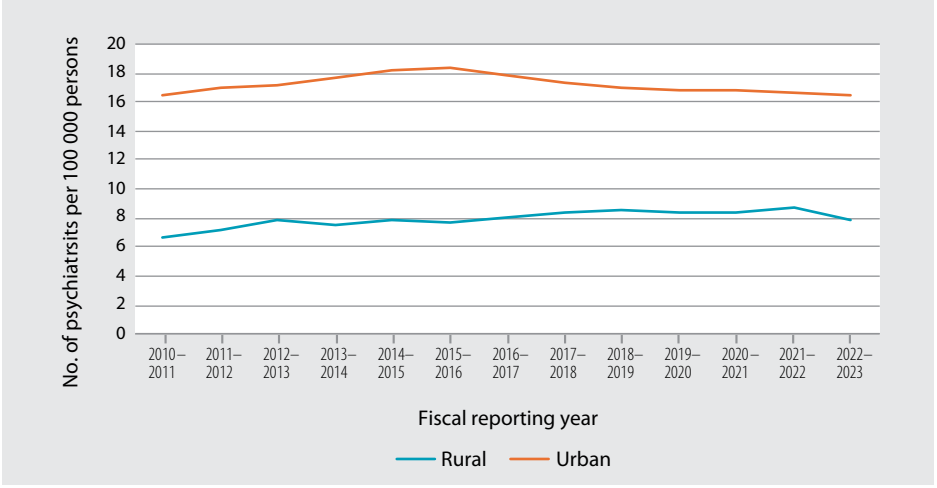


FIGURE 6. Number of psychiatrists per 100 000 persons in rural versus urban Health Service Delivery Areas over time.

In more rural areas, general internists made up a greater proportion of internal medicine specialists than subspecialists, which underscores the importance of rural generalism, a concept that is frequently discussed in primary care literature.[19] General internists have also driven the increase in internal medicine specialists in rural regions that often do not have any subspecialists.

Both urban and rural regions in BC have experienced little change in the number of pediatricians and psychiatrists per capita over time, despite increases in absolute numbers of these specialists. This suggests that the supply and retention of these specialists have not met the demands of population growth. Poor compensation, changing demographics, high call burden, and high

rates of physician burnout may be contributing to stagnant availability of pediatricians and psychiatrists.[16,20,21] For psychiatry, simply increasing the number of psychiatrists alone may not be the solution to this complex problem. Rates of use of psychiatry services increase with the number of psychiatrists per capita, but this correlation plateaus in higher-density urban regions.[16] For example, psychiatrists in high-density urban regions in Ontario see fewer patients and are less likely to take on new patients than those in low-density regions.[22] This may be attributed to practitioners seeing the same patients more frequently, working part-time, or focusing on nonclinical duties such as administrative work or research.[16,22]

Further research and policy development are needed to better support the increasing health care needs of rural BC communities where specialists are less readily available than in urban centres. Factors that influence rural physician recruitment and retention include education, remuneration, regulatory environments, organizational support, peer/professional support, lifestyle, and culture.[5,23,24] Efforts can be made to facilitate social engagement between rural community members and newly recruited rural specialists and their families.[23] Social support should be provided to specialists and their families to ensure their seamless integration into rural communities, especially for clinicians who are new to providing care in Canada. Specialists should be supported in their transition to rural practice through mentorship programs; team building; facilitative organizational factors; and opportunities for upskilling, networking, and career progression.[24]

The University of British Columbia has made efforts to address gaps in rural education by opening its Northern, Interior, and Vancouver Island campuses. Graduates from these campuses are more likely to enter family practice and ultimately to practise in rural communities, particularly if they have a rural background.[4] However, additional efforts are needed to ensure that postgraduate specialty programs are also selecting residents who are interested in serving rural communities and that they are optimally trained for rural practice.[1,4] There is a need for increased postgraduate specialty training opportunities in rural settings, for both residents with an interest in rural practice and those who intend to work in urban centres that will provide tertiary care for rural patients.[4,23] Increasing rural content in medical school and postgraduate curricula, along with rural specialist mentorship programs for interested trainees, may enhance rural specialist recruitment.[23]

In certain HSDAs in BC, a single specialist may be providing care within their specialty to an entire region; this can pose a serious risk of service disruption to entire geographic regions of BC.

The BC Ministry of Health is also working to improve access to rural specialists through various programs, including by providing financial incentives, supporting outreach visits, facilitating locum doctors, and providing rural educational opportunities.[5,25] Streamlining hospital privileging processes and cross-national licensing are also needed to ensure safe and effective rural specialist practice.[26] Current MSP billing codes support easy access to virtual care. While virtual care has significantly reduced barriers to providing health care to remote and rural communities, it remains an adjunct to in-person consultations. The College of Physicians and Surgeons of BC states that "the appropriate use of virtual care includes access to in-person care and is ultimately a professional decision of the registrant made in conjunction with their patients."[27] Virtual care cannot replace the connectivity and trust that an in-person consultation provides, especially for vulnerable patient populations or for the understanding of community context, values, and resources that comes from spending time in rural communities. Virtual care does not provide clinicians with information gained from a thorough physical examination or the ability to assess body language and behavior. Basic medical services such as emergency care and routine measurements (e.g., blood pressure, pediatric growth assessments) are also difficult to support virtually without the added assistance of nursing staff. Additionally, virtual care faces technological limitations related to network connectivity and hardware availability in rural areas, digital literacy of patients and staff, and privacy concerns regarding the use of digital platforms.[28] While exclusive virtual care may be appropriate in specific cases, other situations require in-person assessment or live support from ancillary staff. Virtual care is an important tool in reducing health care barriers in rural settings, but further research and policy guidance are needed to inform the most appropriate balance between in-person and virtual care.

Rural specialists are also improving rural access to specialty care by creating organizations such as the General Rural Internal Medicine (GRIM) and Sustaining Pediatrics in Rural and Underserved Communities (SPRUCe) networks.[8,29] These organizations aim to identify areas of need in rural communities, connect rural communities with locums or visiting specialists, and facilitate interprovider communication between specialist teams in rural and urban communities. They also advocate for rural medicine through providing support and mentorship to learners and clinicians interested in rural medicine.

Rural health care disparities are complex, and multifaceted solutions are essential to ensure all Canadians can access high-quality medical services. Innovative solutions, investments in rural health infrastructure, and increased recruitment and retention of specialists are needed to ensure equitable access to specialist care for rural populations.[13,16]

Study limitations

This study included only internal medicine, pediatrics, and psychiatry; therefore, the findings do not necessarily reflect the distribution of other specialties, including surgical specialties. The data do not account for services provided via telehealth, locum physicians, and visiting outreach models, which are strategies to address the health care gaps in rural BC. The data also do not capture exclusively salaried physicians or types of service, practice setting, hours worked, or volume of patients seen, all of which may affect access to specialist care. The pediatrician data were based on general pediatricians and pediatric subspecialists using MSP pediatric fee codes. Pediatrician and psychiatrist subspecialists were not accounted for separately, which resulted in a knowledge gap in rural access to these disciplines. Additionally, MSP population data were not age adjusted, so both pediatric and adult populations were included.

Conclusions

Overall, we found rural–urban discrepancies in specialist distribution in BC, which have persisted over the past decade. We call upon clinicians and policymakers to address this long-standing issue. ■

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Competing interests

Dr Jaworsky and Dr Warbrick are co-leads of the GRIM network. Dr Miller and Dr Retallack are co-leads of the SPRUCe network. Dr Jaworsky is a member of the *BCMJ* Editorial Board but was not involved in the review and publication decision process for this article.

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Community-based consultant pediatrician perspectives on child and youth mental health in British Columbia

The increasing demand on community-based consultant pediatricians in BC to provide pediatric mental health services appears unsustainable and presents a threat to the long-term viability of their workforce.

Brett Schrewe, MDCM, PhD, FRCPC, Stephen Tsai, MD, FRCPC, Brian Evoy, PhD

ABSTRACT

Background: Child and youth mental health concerns are increasing in Canada, resulting in an increase in visits to community providers.

Methods: We distributed a 14-question survey to members of the British Columbia Pediatric Society (*N* = 309) in February 2025 to explore the role community-based consultant pediatricians (CBCPs) play in delivering pediatric mental health services in British Columbia.

Results: The response rate was 26% (*n* = 81). Mental health care now comprises most of the care that CBCPs provide, and this has increased significantly over the last decade. Due in part to self-directed learning, CBCPs appear comfortable caring for straightforward concerns. Yet, as they shoulder the burden of complex mental health care with insufficient support, they are grappling with burnout and professional sustainability.

Conclusions: The current delivery of BC's pediatric mental health care system has placed CBCPs in an untenable situation. Because this issue threatens the long-term viability of the community pediatric workforce, we need to consider strategies that more effectively meet changing pediatric mental health care needs.

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Background

Optimal mental health is paramount for children and youth to grow and develop to the best of their abilities. However, significant mental health conditions, including attention-deficit/hyperactivity disorder (ADHD), anxiety disorders, mood disorders, autism, and behavior disorders, globally affect nearly 7% of children 5 to 9 years of age and approximately 13% of those 10 to 19 years of age.[1] In Canada, recent estimates indicate that mental illness affects 1.2 million children and youth.[2] The COVID-19 pandemic had significant impacts, with nearly one in five youth who rated their mental health as "good" or better in 2019 reporting declines to "fair" or "poor" by 2023.[3] During the pandemic's peak and aftermath, there were significant increases in hospital admissions for pediatric mental health concerns and deteriorations in mental well-being.[4] Yet even in the decade prior to the pandemic, these concerns in Canadian children and youth were increasing. Thirty-nine percent of Ontario students in grades 7 to 12 reported a moderate to severe level of psychological distress,[5] while anxiety disorders doubled in the pediatric population.[6]

There is international consensus that countries should provide comprehensive pediatric mental health services because they are "essential to realize [children and youth's] full rights, [to] ensure that they can meet their potential, [to] alleviate unnecessary suffering, and to enable sustainable development and foster prosperous, stable communities."[7] Community physicians, including pediatricians, are one component of this system of care; over the last 6 years in Canada, they have seen a nearly 10% increase in child and youth visits for mental health concerns.[8] In this context, and with the improvement of child and youth mental health care as one of the Canadian Paediatric Society's current strategic priorities,[9] we sought to better understand the current role that community-based consultant

pediatricians (CBCPs) play in the delivery of these services in British Columbia.

Methods

Study design

Following iterative discussions with British Columbia Pediatric Society Advocacy Committee members, we developed a 14-question survey to explore the perspectives of CBCPs regarding their experiences with providing mental health care. The survey included closed- and open-ended questions to assess the volume and complexity of mental health care CBCPs provide, their comfort and training in providing such care, perceived supports, and impacts on their well-being and career plans. We distributed the survey, in English, by email in February 2025 to 458 recipients, including all members of the British Columbia Pediatric Society and the American Academy of Pediatrics–BC Chapter. We obtained responses confidentially through a secure online platform (SurveyMonkey).

Data collection and analysis

The British Columbia Pediatric Society compiled the initial results of this study. We included only actively practising members of the British Columbia Pediatric Society or the American Academy of Pediatrics–BC Chapter (N = 309; British Columbia Pediatric Society: 222 active members, 17 associate members, 35 first-year-in-practice members; American Academy of Pediatrics–BC Chapter: 35 members). We excluded residents (n = 119), medical students (n = 19), and retired or administrative members (n = 17). We collated responses to closed-ended questions to develop a picture of the contexts in which CBCPs currently practise, determine the current percentage of their clinical work they devote to mental health care, and establish trends in these efforts over time. We analyzed free-response questions thematically.[10] B.S. developed initial codes from the data, which were then reviewed by S.T. and B.E.; B.S. then constructed provisional broader themes, for which the research team achieved consensus through discussion.

Ethics

Because this study was conducted under the aegis of programmatic improvement, it was exempt from ethics review, in keeping with the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, Article 2.5.

In Canada, recent estimates indicate that mental illness affects 1.2 million children and youth.

Results

Eighty-nine participants responded to the survey. Eight were removed because they either were still in residency (n = 1) or were not providing any aspect of community-based general pediatric care (n = 7). As a result, our adjusted response rate was 26% (81/309). Closed-ended results are presented as absolute numbers or percentages; free-response results are presented as themes supported by percentages and exemplar quotations **[Box]**. Denominators vary slightly for free-response results because not every participant responded to every question.

Practice context

Fifty-four percent of respondents (44/81) worked in more than one clinical setting. Seventy-nine percent (64/81) worked in an outpatient community-based practice; 28% (23/81) worked solely in that context. Fifty-three percent of respondents (43/81) worked in a community hospital with specific pediatric inpatient services; 11% (9/81) worked in a community hospital that lacked pediatric-specific services. Sixteen percent of respondents (13/81) who worked in an outpatient community-based practice also worked in the province's sole pediatric tertiary-quaternary centre. Seventy-five percent of respondents (61/81) worked in a large population centre (more than 100 000 people), 22% (18/81) worked in a medium-sized population centre (30 000 to 100 000 people), and 16% (13/81) worked in a small population centre (1000 to 29 999 people). Fourteen percent of respondents (11/81) worked in more than one population centre.

Mental health care provision over time

Ninety-four percent of respondents (76/81) spent at least 50% of their time working with children with mental health concerns; 53% (43/81) spent 75% or more of their time **[Figure 1]**.

To establish trends over time, we compared how perceptions of the amount of time spent providing services to children with mental health concerns changed among respondents who had worked for 5 years or longer (n = 62) and those who had worked for 10 years or longer (n = 46). Of those who had worked for 5 years or longer, 95% (59/62) spent at least 50% of their time working with these children; 56% (35/62) dedicated at least 75% of their time to that work **[Figure 2]**. Fifty-three percent (33/62) recalled spending more than half their time working with this population 5 years prior, while only 13% (8/62) recalled spending 75% or more of their time **[Figure 3]**.

For respondents who had worked for 10 years or longer, 91% (42/46) spent at least 50% of their time working with children with mental health concerns; 54% (25/46) spent at least 75% of their time working with them **[Figure 4]**. Fifty percent (23/46) recalled spending at least half their time working with these children 5 years prior, while 11% (5/46) recalled spending 75% or more of their time. Twenty-eight percent (13/46) recalled spending half their time or more with this population 10 years prior, while only one respondent recalled spending more than 75% of their time **[Figure 5]**.

Free responses

Free-response questions focused on CBCP perspectives on their comfort with providing mental health care and their ability to do so, relevant residency training, additional

learning/training undertaken, how well they felt their care delivery was supported by other services, and the impacts of this care on their personal and professional lives.

Comfort level and overall individual ability: Eighty percent (63/79) of participants felt comfortable caring for children and youth with straightforward mental health concerns. However, they felt ill at ease with complex presentations and felt that this level of care was beyond their scope.

Postgraduate training and continuing professional development: Respondents' comfort level with treating straightforward mental health concerns did not appear to result from preparation through residency. Ninety-four percent (76/81) reported they had no or only minimal postgraduate training for this kind of care; 89% (72/81) felt that they were, at best, minimally prepared to provide effective care for these concerns when they started independent practice. Relevant training that was reported included psychiatry rotations/electives (n = 21), community pediatric rotations (n = 11), developmental pediatric rotations/electives (n = 9), and adolescent medicine electives (n = 5).

BOX. Exemplar quotations.

Supports from other services

Overall perceptions

- "I feel like I have no support." (R75)
- "Absolutely terrible support and getting worse. A crisis." (R87)
- "Poorly. Inefficient. I am not an intake worker. Why am I holding the bag? How has this happened? Nobody would design a system like this." (R55)

Perceptions of community-based supports (e.g., Child and Youth Mental Health [CYMH])

- "CYMH exists in my community, but every patient who ever calls is told that their child doesn't meet [the] criteria. . . . I would guess about 1% of the kids that we are following who have tried to access CYMH supports have ever actually seen a psychiatrist for help with medication options." (R57)
- "CYMH continues to reject most 'mild' cases (including patients who are suicidal). . . . CYMH also does not seem to be able to provide adequate counseling/therapies for most patients. The lack of transparency of what CYMH is actually providing is a huge hindrance for working in the community." (R91)

Perceptions of support from child and adolescent psychiatry consultative services

- "I do not feel well supported by psychiatry, in terms of both availability and helpfulness." (R25)
- "I refer to psychiatry when patients are complex and often need longer-term follow-up. So, it is frustrating when they don't see them more than once. . . . For example, I am not trained in or comfortable starting antipsychotics like aripiprazole. I do not feel that this is my role as a pediatrician." (R47)
- "Psychiatry provides a good one-time consultation, but most of the cases I refer require ongoing follow-up . . . [and having the consult response offer] a list of medication options (e.g., 'Try this, and if this doesn't work, [you] can try this one, then add this one') is not that helpful, as I often have no experience with any of the meds suggested." (R66)

Perceptions of support from the Compass program (physician-to-physician virtual call support program)

- "Compass is helpful for very specific questions such as medications. For more complex questions around behavioral approaches, systems navigation, youth and family engagement, we need more hands-on support [rather] than a list of recommendations that are impossible to implement on our own." (R65)
- "Compass has become more useful over the years. However, sometimes I just need somebody else to see the patient, not to base a diagnosis on my impression of what is going on. The drawback of only getting physician-to-physician advice is that I don't know what I don't know. I am only able to ask the patient what I know and then present to the consultant what I see, rather than have them actually assess patients for themselves and perhaps come up with a different conclusion." (R70)

Comfort level and overall individual ability

- "I feel confident in my scope as a general pediatrician in managing cases of moderate severity and complexity. I am not confident—nor do I believe I should be—in providing care to highly complex psychiatric patients (e.g., repeated psychiatric admissions, polypharmacy, multiple comorbid diagnoses with social complexities)." (R44)
- "I have gotten better over the years at managing straightforward ADHD, anxiety, academic difficulties. But once you have medication failures, multiple meds, more complex mental health issues such as bipolar, substance use, eating disorders, a community clinic without access to mental health support is absolutely not enough." (R59)

Professional and personal impacts

Impacts on overall well-being

- "The burden of caring for kids with such a high level of acuity of complex needs—behavioral and mental health—is exhausting, especially with so little community support. At least 30% of the kids I see need a team approach, family therapy, [cognitive-behavioral therapy] for kids, advocacy for school. And instead, they get one harried pediatrician trying to hold up the system." (R29)
- "I'm tired and on the edge of burnout. . . . I feel dumped on—the subspecialist sees when the patient is in crisis, and recommendations are then made for the pediatrician to do a list of things. . . . There is no psych follow-up consistently offered." (R52)
- "Very stressful. I often look at my list of appointments for the next day and start feeling anxious. I feel that I am not doing what I trained for." (R68)

Impacts on professional longevity and practice sustainability

- "This is my main source of frustration in my office world. I have OFTEN contemplated how I could decline any more of these referrals to affect my own mental health and reduce burnout but do not think I can do this. Instead, I dream about quitting office practice . . . and I am not that old!" (R42)
- "It's been extremely difficult, and I feel like I've had to put a lot of time to learn how to do this work with minimal support. It can be very demoralizing. And yes—it definitely makes me want to leave pediatrics." (R53)
- "I almost left practice a year ago and have thought several times about moving to hospital-based work only. I was completely burned out." (R83)
- "I will be leaving community practice and moving to a hospital clinical associate position. I often feel overwhelmed, unsupported, and out of my depth with my mental health/behavior patients. I was not trained to manage these patients through residency." (R24)
- "I will retire ASAP because of this trend. It makes me hate my office a large proportion of time, and I feel helpless to change it." (R87)

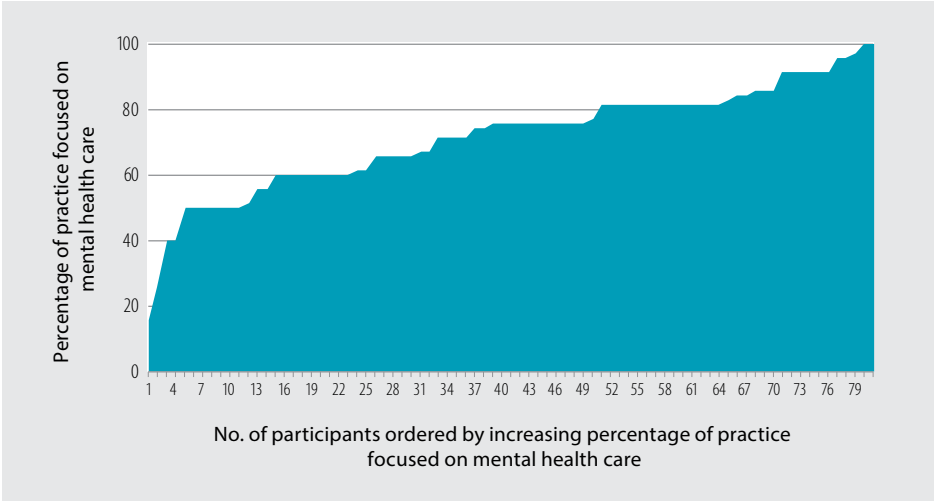

FIGURE 1. Percentage of current practice spent working with children with mental health concerns (all respondents: *n* = 81).

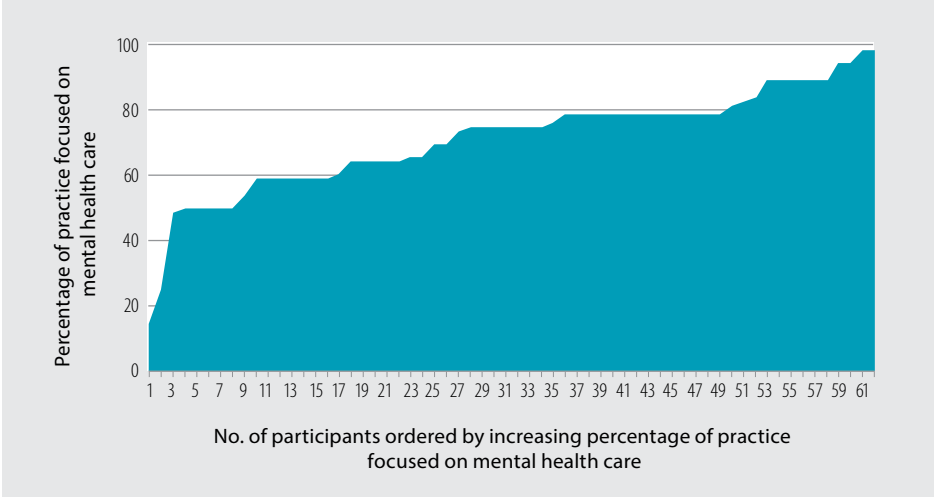

FIGURE 2. Percentage of current practice spent working with children with mental health concerns (those working for 5+ years: *n* = 62).

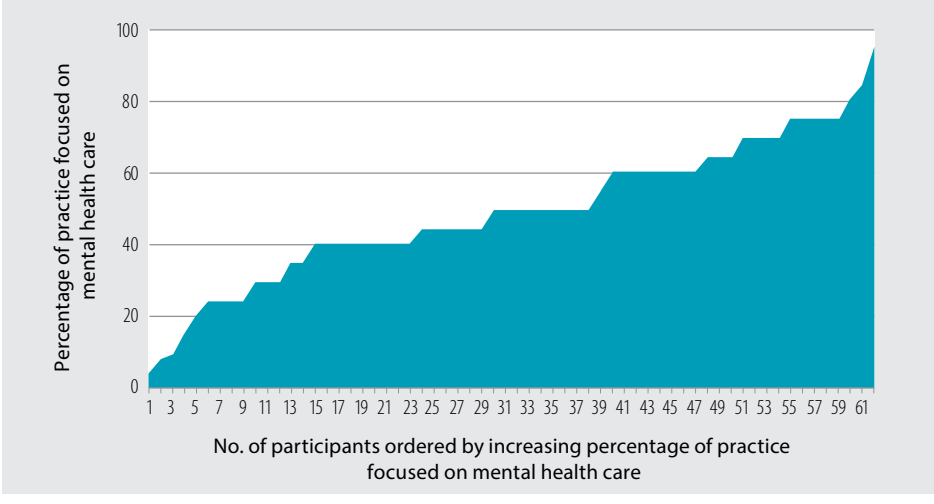

FIGURE 3. Percentage of practice spent working with children with mental health concerns 5 years ago (those working for 5+ years: *n* = 62).

To fill this gap in training, 84% (64/76) of respondents had engaged in professional development activities. Of these 64 respondents, 89% sought out structured continuing medical education (e.g., conferences offered by the Canadian ADHD Resource Alliance, Canadian Paediatric Society, and British Columbia Pediatric Society), 47% had engaged in self-study and/or participated in journal clubs or webinars, 41% had taken a formal course such as CanREACH (a focused training program on child and youth mental health targeted at primary care providers)[11] or learned cognitive-behavioral therapy, and 22% described experiential learning through providing mental health care and/or discussing care strategies with pediatric colleagues.

Supports from other services: While respondents had developed comfort with treating certain concerns, they recognized that effective mental health care provision requires myriad other supports. Seventy-nine participants described how they felt with respect to other mental health or psychiatric services. Of those who described their perceptions overall, 87% (33/38) felt poorly supported, and 84% (38/45) felt that no or only marginal community-based supports were readily available, such as assessment and treatment options that the provincial Child and Youth Mental Health service ostensibly provides.

Sixty-three percent of respondents (31/49) described poor access to child/adolescent psychiatry, an issue that is compounded by the fact that children with significant mental health complexity are often assessed only once, and no longitudinal follow-up is provided. Some respondents found the provincial Compass program—in which CBCPs remotely review a case with a psychiatrist and receive advice—to be more useful. Fifty-five percent (30/55) said Compass had moderate utility, but 33% (18/55) found that it was not helpful. However, even those who felt that Compass had some use raised concerns about the variability of support and the cumbersome process of getting

advice; they also felt that it was not a legitimate substitute for psychiatric evaluation.

Personal and professional impacts: Respondents described significant negative impacts on their overall well-being. Eighty-six percent (68/79) said that the current scope of mental health care they provide is exhausting and causes anxiety, burnout, and moral distress. Due to these care experiences and current demands, 42% (33/79) are considering reducing or no longer offering mental health care, leaving community pediatrics, or even leaving the profession. Another 14% (11/79) have already closed their wait list, altered their practice, or made definitive plans to leave the profession entirely.

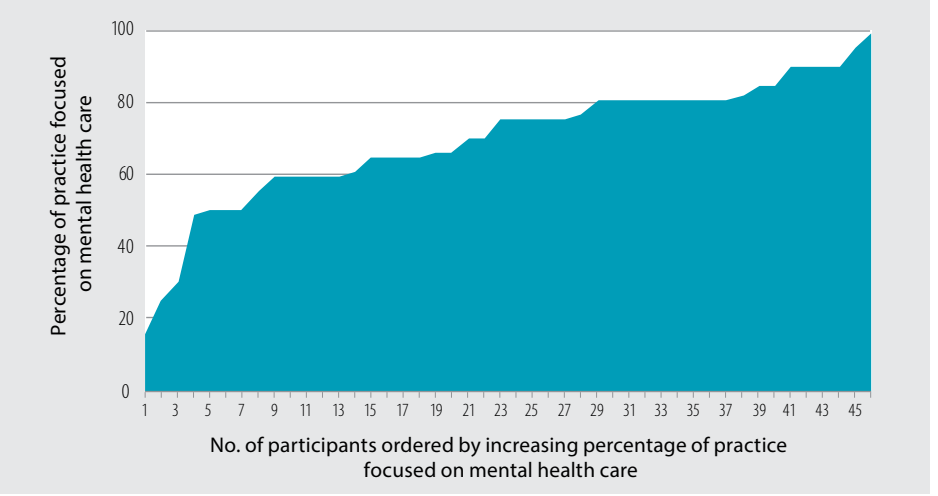

FIGURE 4. Percentage of current practice spent working with children with mental health concerns (those working for 10+ years: *n* = 46).

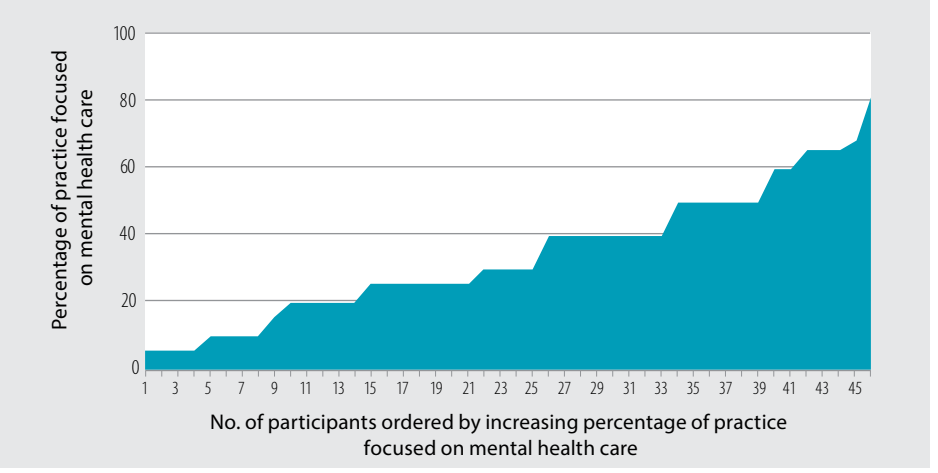

FIGURE 5. Percentage of practice spent working with children with mental health concerns 10 years ago (those working for 10+ years: *n* = 46).

Discussion

Our results suggest that mental health concerns have increased significantly over the last decade and now comprise most of the care that CBCPs in BC provide. While the CBCPs in this study had no or only minimal relevant mental health care training prior to independent practice, they nonetheless appeared to be comfortable caring for children and youth with straightforward mental health concerns. This level of comfort is a result, at least in part, of their proactive participation in continuing professional development and their commitment to experiential learning about these issues.

There is no question that pediatricians have an important role to play in helping treat pediatric mental health concerns,[12,13] particularly as society's needs in this area increase and in light of estimates that less than 20% of children and youth receive appropriate treatment.[14] However, CBCPs are increasingly the principal care providers for those with significant mental health needs and high burdens of care, despite persistent concerns that this level of complexity is far beyond their scope and that they are receiving variable—and often wholly inadequate—supports from community and subspecialist mental health providers. For example, the provincial Child and Youth Mental Health program, which is intended to provide comprehensive primary and secondary mental health services,[15] is hampered by long wait lists and a scarcity of providers and funding.[16] Further, the persistent shortage of child/adolescent psychiatrists[17] has significantly constrained subspecialty assessment, management, and longitudinal follow-up. The Compass program is a valiant attempt to maximize the resources that support community providers.[18] Yet even innovative programs like Compass may inadvertently increase the burden on CBCPs. Instead of being able to refer a patient directly to psychiatry, CBCPs must invest significant time and administrative costs to receive Compass advice about a patient that the psychiatrist has never seen. In turn, CBCPs remain responsible for the effective and safe implementation of the recommendations provided, even if they are beyond the CBCP's scope, and their potential utility may go unrealized in a community setting due to a lack of available resources.

Ultimately, the lack of child/adolescent psychiatrists and robust community mental health infrastructure highlights critical gaps in our health care system, which are a concern in a high-income country where high-quality, equitable, and accessible health care is considered a social right.[19] Although CBCPs find themselves in the unenviable position of having to make up the deficit

in care, many have found time to develop additional skills to address the need. This is a testament to their commitment to the children and youth they serve. Yet their ongoing efforts to address pediatric mental health concerns are having negative impacts on their personal well-being and professional longevity in community-based practice, which is threatening the sustainability of the community pediatric workforce.

Calls to action

How might we move forward? While we did not solicit participants' ideas for improvement, our results nonetheless demand action to address their concerns. We offer four recommendations and two broader considerations that will help all interest holders move forward in ways that better provide the kind of mental health care that children and youth need and deserve.

First, we suggest that current wait times for psychiatric consultation should be reduced significantly and pathways for longitudinal care, rather than single consults, should be created. Specifically, it is important to establish a fast-track system for complex or refractory cases, where patients can be assessed by psychiatrists in an expedient manner if pediatricians are struggling after initial interventions or if Compass advice has proven insufficient.

Second, the Compass program, while well intentioned, needs to be reformed and enhanced to ensure consistent, effective support is provided. CBCPs should have direct access to psychiatrists rather than spending considerable time moving through multiple gatekeeping steps with intake workers.

Third, instead of forcing CBCPs to shoulder sole responsibility for the care of children with complex mental health needs, comprehensive and adequately funded team-based care models that foster seamless collaboration between family physicians, pediatricians, allied health care professionals, and psychiatrists must be put in place. Leveraging the experiences and drawing on the examples of both the Child and Youth Mental Health and Substance Use Community of Practice[20] and Foundry[21] may provide some concrete guidance on this front.

Fourth, large investments in primary and secondary child and youth mental health services are long overdue, echoing others' calls for "right-sizing" children's health care systems and for mental health to be a key pillar of a pan-Canadian child health strategy.[4]

It is past time to update decades-old legislation to align with the mental health needs of Canadians in 2026 and for the public system to cover the cost of professionals whose training and purview are centred on mental health.

More broadly, we also highlight two deeper considerations.

First, the Canada Health Act aims, in part, "to protect, promote and restore the mental well-being of residents of Canada."[22] However, the narrow range of services that it compels provincial and territorial health insurance plans to provide includes only mental health services provided by physicians or in hospitals. As a result, there is significant heterogeneity in the kinds of mental health care services and prescriptions that are covered by various jurisdictions.[23] This frequently leads to substantial and prohibitive out-of-pocket costs for families in accessing counselors, psychologists, and therapists;[24] as a result, they have little recourse but to continue to seek help from physicians like CBCPs, whose services are free at the point of care. It is past time to update decades-old legislation to align with the mental health needs of Canadians in 2026 and for the public system to cover the cost of professionals whose training and purview are centred on mental health.

Second, given current concerns about mental health care delivery, it seems reasonable for departmental and educational leaders to improve pediatricians' skill sets through training. For example, one current entrustable professional activity in pediatric residency focuses on "assessing and managing patients with mental health issues,"[25] yet residents need only two successful encounters in the community to pass this requirement. However, efforts to equip future CBCPs with expanded competencies to deliver complex mental health care risk reinforcing the very system of care delivery that created this problematic gap to begin with. Such measures may paradoxically delay urgently needed reform of child and youth mental health services, while implying that the current setup—which is already having significant negative impacts on CBCPs—is somehow acceptable or sustainable. Preparing trainees to take on more mental health care responsibilities does nothing to address the root causes of the issue and may leave CBCPs unfairly burdened with propping up a fragmented and underresourced system they did not create.

Study limitations

We did not explore any of the concerns identified by CBCPs in greater depth. In addition, our study's BC-centric focus may limit its generalizability to other provincial and territorial jurisdictions, whose health care systems may differ in their organization and service offerings. Further, the reported trends in mental health care over time may be distorted by recall bias. Finally, although there was a response rate of nearly 30%, the CBCPs who did not respond may have different opinions from those reported. Therefore, our results may be skewed and may provide an inaccurate depiction of the current state of pediatric mental health care provided by CBCPs.

Conclusions

The mental health care needs of Canadian children and youth are increasing in both scale and complexity. CBCPs in BC are doing what they can in response, yet their personal well-being and professional longevity are being increasingly compromised

by having to work beyond their scope and with insufficient supports from both primary and subspecialty mental health services. While our results represent only one snapshot of one jurisdiction, the current situation appears unsustainable and presents real threats to the long-term viability of the community pediatric workforce. As a result, we must move beyond short-term, reactive fixes that shift the burden of care onto CBCPs. Instead, we must commit to creating sustainable solutions that improve timely access to appropriate mental health care professionals, while also redesigning a mental health care system that is capable of providing the kind of care that Canadian children and youth need, when and where they need it, in the years to come. ■

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Competing interests

None declared.

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Micronutrient deficiencies in children: Key drivers in BC

Micronutrients are essential vitamins and minerals required for normal growth, development, and metabolic function. In childhood, they support neurodevelopment, immune function, and bone health. Rapid growth in infancy, early childhood, and adolescence increases susceptibility to deficiency.[1] Childhood obesity rates in Canada have tripled in recent years, intensifying the "double burden" of malnutrition—where excess caloric intake coexists with micronutrient deficiency.[2]

In BC, 86% of school-aged children fail to meet the minimum guidelines for fruit and vegetable intake, indicating a population-level dietary risk across socioeconomic groups.[1] Structural factors—including poverty, systemic racism, and migration-related barriers—further influence dietary access and nutritional outcomes.[3,4]

Rural and urban children at risk

The drivers of pediatric micronutrient deficiencies vary between rural and urban settings. Rural and remote communities—including northern regions and many Indigenous populations—experience higher rates of food insecurity and poverty and persistent barriers in the health system.[3] Interruptions to traditional diets, prolonged breastfeeding without complementary iron-rich foods, and early introduction of cow's milk contribute to iron and vitamin D deficiency. Environmental factors, including limited sunlight exposure and geographic isolation, further increase the risk of vitamin D–deficiency rickets and iron-deficiency anemia.[5] Gaps in routine screening and supplementation programs also exacerbate inequities in rural communities.

In BC, 86% of school-aged children fail to meet minimum guidelines for fruit and vegetable intake.

In urban settings, children commonly consume energy-dense, nutrient-poor processed foods. Socioeconomic disparities, limited time for family meal preparation, and the nutritional impacts of acculturation in newcomer families contribute to inadequate intake of vitamin D, calcium, magnesium, and B vitamins.[4] Despite broader food availability, many urban households still face barriers to nutrient-dense diets.

Newcomer and refugee children

Newcomer children are at increased risk of vitamin and mineral deficiencies due to premigration food insecurity, limited access to fortified foods, and infectious disease exposures. Caring for Kids New to Canada identifies vitamin A deficiency as a common condition in newcomer children, which may be unfamiliar to some practitioners, presenting with night blindness, xerophthalmia, and an increased susceptibility to severe infections.[4] Iron deficiency and iron-deficiency anemia frequently accompany migration and may persist if financial or cultural barriers limit access to nutrient-rich foods postarrival.[4]

Micronutrient deficiencies interact bidirectionally with infection. Infectious diseases deplete stores of iron, vitamin A, and zinc, while deficiencies increase the severity and duration of infection.[6]

Dietary patterns and restrictive eating

Shifts away from traditional or whole-food diets toward ultra-processed foods decrease micronutrient density. Children following vegetarian, vegan, gluten-free, or highly selective/neurodivergent eating patterns are at increased risk for inadequate intake of vitamin B12, iron, vitamin D, zinc, and calcium without targeted dietary planning.[7]

Environmental determinants

Climate change is an emerging determinant of nutrient intake. Increased atmospheric CO_2 levels reduce iron, zinc, and protein content in staple crops, posing long-term risks for population nutrition.[8] BC's dependence on imported foods increases vulnerability to global supply chain instability.

Addressing micronutrient deficiency

Clinicians should remain alert for signs of deficiency. Vitamin A deficiency may present with visual changes; vitamin C deficiency with musculoskeletal pain or gingival abnormalities; and iron deficiency with fatigue, pallor, or developmental concerns.[3,5]

Key interventions include culturally responsive nutrition education, universal nutritional screening at child and newcomer health visits, targeted supplementation, food fortification programs, and strengthened provincial nutrition surveillance. Addressing food insecurity through income supports, school meal programs, and access to culturally relevant foods is foundational to improving child nutrition across BC. ■

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Silicosis and emerging risks to patients working with engineered stone

Silicosis is caused by inhalation of respirable crystalline silica (RCS) particles less than 5 µm in diameter, which are small enough to reach the alveoli to trigger lung injury and persistent inflammation. This can lead to lung fibrosis and nodular changes.[1] Silicosis has long been associated with occupational exposure in the mining and quarrying industries. However, new sources of RCS exposure are emerging, leading to earlier onset of silicosis. Individuals who work with silica-based materials in construction or manufacturing—particularly installing or manufacturing engineered stone materials, such as countertops—may be at risk of developing accelerated silicosis.[1]

Silicosis phenotypes

The intensity and duration of exposure to RCS can impact the type of silicosis patients develop. The most common presentation is chronic silicosis, which develops slowly over decades, involves lower-level exposure, and presents later in life (typically when the patient is in their 60s or 70s). Accelerated silicosis has a shorter latency period (5 to 10 years) and involves higher exposures over shorter periods of time. Acute silicosis is a rare phenotype involving very high exposures over weeks or months, which leads to a rapid onset of symptoms and lung injury.[2] Once established, silicosis is irreversible and progresses even after exposure stops. This results in predisposition to other lung diseases (e.g., chronic obstructive pulmonary disease, lung cancer, tuberculosis).[2]

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Emerging and ongoing exposures

An estimated 57 000 workers in BC are exposed to silica each year, with 64% of these workers at risk of high exposures.[3] Workers can be exposed to RCS through activities such as tunneling; sandblasting; ceramic work; and sanding, cutting, drilling, grinding, crushing, demolition, and cleanup of silica-based materials such as concrete, cement, asphalt, bricks, and stone materials, including countertops.

Engineered stone, an alternative to granite or marble, is increasingly being used for kitchen and bathroom countertops, stone veneer cladding or siding stone, flooring, and decorative elements (e.g., columns, fireplace surrounds). Compared with natural stone, engineered stone contains a higher proportion of crystalline silica (> 90% silica in engineered stone vs approximately 45% in granite and 5% in marble).[4]

Chronic silicosis is the more common presentation for individuals who work in mines or quarries, whereas accelerated silicosis may be a more common presentation for workers exposed to high levels of RCS, with presentation more common among younger individuals (median age 33 to 55 years).[4]

Clinical features and assessment of silicosis

Silicosis rates can be challenging to determine, as silica-related diseases and mortality are estimated to be underreported by a factor of 2.5 to 5.[5] Early silicosis may be asymptomatic or with subtle findings. Typical features include dyspnea on exertion, persistent nonproductive or mildly productive cough, fatigue, reduced exercise tolerance, chest tightness, occasional chest pain, and weight loss in more advanced cases.[2] If a patient presents with unexplained progressive dyspnea and cough and has a relevant occupational history, include silicosis on your differential. An occupational history is critical and includes asking about the following:

- All jobs ever held (particularly in construction, mining or quarrying, countertop stone fabrication, masonry, tunneling, foundries, sandblasting, or demolition).
- Exposure to RCS (e.g., exposure to dust from engineered stone, sandstone, granite, or other mineral-based materials, as well as concrete, mortar, and brick).
- Job activity specifics (e.g., use of powerful air-blowing or air-lance tools for cleanup).
- Duration on the job (years) and intensity (hours per day).
- Use of wet methods (i.e., use of water to reduce exposure to dust), ventilation, and personal protective equipment (specifically, type of respirator used), and other known safety measures for silica control used at the workplace.
- If and when exposure has ended.

A history should also include information on smoking, as well as previous TB or other lung diseases.

Testing and early management

If silicosis is suspected, investigations include a chest X-ray and pulmonary function tests, along with potential screening for TB infection or disease.[2] Indicate "occupational exposure to silica; suspect silicosis" on requisitions.

Chest X-ray has limited sensitivity to detect silicosis. If chest X-ray is equivocal

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or an atypical presentation is suspected, consider a high-resolution CT or referral to a respirologist for further investigation.[6,7] Pulmonary function tests typically demonstrate a restrictive defect; however, in late-stage disease, there can be mixed defects with obstruction, restriction, and impairment in gas transfer.[2]

In addition to symptom management and RCS avoidance, early management involves minimizing other pulmonary risks. This includes smoking cessation, influenza and pneumococcal immunization, and monitoring and management of comorbid conditions (e.g., chronic obstructive pulmonary disease, pulmonary hypertension, kidney disease).[2]

If you have a patient with a WorkSafeBC claim or suspect silicosis, please indicate on your Form 11 that you would like your patient to be referred to a respirologist or to the WorkSafeBC Visiting Specialist Clinic (respirology). You can also reach a WorkSafeBC medical advisor on the RACE app+ to discuss your patient's case. If you have concerns about the RCS exposure described by your patient, reach out to WorkSafeBC's prevention team at 604 276-3100 (Lower Mainland) or 1 888 621-7233. For more information, visit www.worksafebc.com/silica. ■

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Strengthening rural emergency care by meeting physicians where they are

Rural emergency physicians work in some of British Columbia's most challenging clinical environments, defined by high-acuity presentations, limited on-site resources, variable transport times, and persistent staffing pressures. Through the Joint Collaborative Committees (JCCs)—a partnership between Doctors of BC and the BC government—community-based initiatives provide supports tailored to rural and remote realities, strengthening clinical capacity, workforce sustainability, and physician well-being.

A central role is played by the Joint Standing Committee on Rural Issues (JSC), which funds the Rural Coordination Centre of BC (RCCbc). This sustained investment enables RCCbc to deliver programs grounded in the lived experiences of rural physicians, supporting hands-on clinical training, peer networks, physician retention, and local system resilience. These supports are widely recognized by rural physicians as invaluable to maintaining high-quality rural medical practice in communities across the province.

Virtual caregiving and education

For rural clinicians managing urgent and complex cases, the Real-Time Virtual Support (RTVS) program, administered by RCCbc, reduces professional isolation and provides a critical safety net. Launched in 2020, RTVS connects rural providers with real-time clinical guidance via Zoom or phone from on-call physicians familiar with rural practice.

RTVS includes pathways supporting emergency medicine, pediatrics, maternity care, critical care, and internal medicine. An additional pathway provides overnight emergency department coverage, while specialist "quick reply" pathways offer targeted support during weekday business hours.

Since 2020, RTVS has supported clinicians in 168 rural communities, responded to more than 100 000 calls, saved over 12 500 hours of potential emergency department diversions, strengthened team-based care, and expanded equitable access to specialist expertise across the province.

Training for trauma at home

Leaving town for education and training can be difficult when staffing is limited and travel to urban centres requires days away. Bringing training directly to communities is the foundation of the CARE Course, funded by the JSC and administered by RCCbc. This program includes a 2-day, hands-on course for rural physicians and interprofessional teams focused on high-acuity, low-occurrence events, including trauma, cardiac care, and obstetrical and pediatric emergencies.

Diagnostic confidence and rapid treatment options are further strengthened through point-of-care ultrasound training, also funded by the JSC. Delivered through UBC's Rural Continuing Professional Development Program, the Hands-On Ultrasound Education course provides hands-on training in rural communities, supporting care for early pregnancy bleeding, abdominal pain, cardiac presentations, and more.

Simulation-based training in rural BC hospitals offers another critical layer of preparedness. Through the Specialist Services Committee's Facility Engagement Initiative, teams rehearse high-stakes emergency scenarios that occur infrequently but demand readiness. At Sechelt | shíshálh Hospital, emergency department simulations enable physicians and nurses to work through system-level issues—such as ordering the massive hemorrhage protocol—and practise high-risk procedures, including managing postpartum hemorrhage and inserting chest tubes, while identifying and addressing knowledge gaps. This training also supports adaptation to new technology and equipment and strengthens team communication. By practising these events, teams are better prepared to deliver safe, effective, and coordinated care in fast-paced emergency settings.

Developing sustainable human health care resources

Even with these supports, rural communities continue to face recruitment and retention challenges that require solutions designed for local contexts. The Rural Locum Program, funded by the JSC, provides a suite of programs and centralized resources that connect locum physicians with rural practices, strengthening recruitment, retention, and continuity of care.

Innovative staffing models are also helping reduce physician burnout. At Kootenay Boundary Regional Hospital, a pilot ICU clinical associate program—funded through the Specialist Services Committee's Facility Engagement Initiative—deploys trained emergency physicians to support

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This article is the opinion of the Joint Collaborative Committees (JCCs) and has not been peer reviewed by the BCMJ *Editorial Board.*

Syphilis: Shifting trends in BC and new tools for clinical practice

Syphilis, caused by the spirochete *Treponema pallidum*, is a sexually transmitted infection that can lead to significant adverse outcomes across organ systems if left untreated.[1] Syphilis has a well-earned reputation as "the great imitator," as it can impact any organ system and present in a variety of ways. Because no immunity develops, reinfection after treatment is a risk with subsequent exposures. Infectious syphilis is usually categorized into primary, secondary, and early latent syphilis. Late latent syphilis is considered non-infectious. In BC, there is a stage called latent syphilis of unknown duration, which may or may not be infectious. Vertical transmission during pregnancy or delivery can result in miscarriage, stillbirth, or congenital syphilis, which poses significant health risks to infants.[1]

British Columbia declared a syphilis outbreak in 2019 following a sharp rise in cases and the re-emergence of congenital syphilis.[2] Given the current outbreak and change in epidemiology, we encourage clinicians to think about syphilis and offer testing. For comparison, in 2010 (pre-outbreak), the rate of infectious syphilis was 3.4 per 100 000.[3] By 2019, this had increased to 20.9 per 100 000. In 2023, the rate peaked at 37.5 per 100 000. Rates have been stable since 2025 but remain high compared with pre-outbreak levels.[3]

Historically, gay, bisexual, and other men who have sex with men accounted for most reported cases. However, a notable shift in the epidemiology occurred during the outbreak toward rising rates among heterosexual populations, particularly women, and increased incidence among individuals experiencing unstable housing and substance use. Between 2019 and 2024, syphilis rates also rose significantly in regions outside major urban centres, with the Northern Health Authority experiencing a rate increase of over 2000% and the Interior Health Authority seeing a 278% rise.[3,4]

British Columbia declared a syphilis outbreak in 2019 following a sharp rise in cases and the re-emergence of congenital syphilis.

While smaller population sizes amplify rate changes, the geographic expansion of cases into more rural and remote areas signals an important trend for health professionals to be aware of. A notable rise among pregnancies complicated by syphilis has seen the return of congenital syphilis, a previously rare occurrence, with no congenital cases reported in the province from 2013 to 2018. In 2019, five congenital syphilis cases were identified, with case counts increasing annually to 27 cases in 2024. An additional 11 congenital syphilis cases were reported in the first two quarters of 2025.[3,4] Updated screening recommendations have been implemented for pregnant individuals to be screened twice in the perinatal period: the first in the first trimester or at the first prenatal visit, and the second at delivery or anytime after 35 weeks for home births.

We have developed new communication tools to help busy clinicians stay aware of the changing trends; to help clinicians think about and test for syphilis, including swabbing lesions; to assist with serology; and to help clients understand disease risk, prevention, and treatment options. These tools include:

- An infographic. Traditional surveillance resources, such as the new interactive *Sexually Transmitted and Blood Borne Infection (STBBI) and Tuberculosis (TB) Surveillance Report*[4] and key trend reports,[5] offer comprehensive data but may not clearly highlight emerging trends for busy clinicians. To address this, a concise and visually accessible infographic was created to summarize key findings from the outbreak **[Figure]**.
- A tool kit for health professionals. Complementing the infographic is a tool kit, which includes:
  - A quick-reference handbook for recognizing clinical presentations and testing methods.
  - Serology interpretation guides.
  - Patient education materials.

To download the infographic and tool kit, including posters and patient education materials, visit www.bccdc.ca/health-professionals/clinical-resources/syphilis-toolkit.

Anyone who is sexually active can get syphilis. Clinicians are encouraged to consider syphilis screening for patients with sociodemographic risk factors, including unstable housing and substance use, and add syphilis blood work to routine screening for sexually transmitted infections. For symptomatic presentations, ensure lesions are swabbed along with submitting blood work to aid in infection staging. Sample requisitions and reference tools for specimen collection are available in the tool kit for health professionals. For assistance with syphilis case management or follow-up, contact the BCCDC public health nurse at 604 707-5607 or physician

This article is the opinion of the BC Centre for Disease Control and has not been peer reviewed by the BCMJ *Editorial Board.*

at 604 707-5610. To request a digital copy of the *Syphilis Handbook* or a printed version of the full tool kit, email sticourse@bccdc.ca. ■

—Julie Holt, RN, MHM
Senior Practice Leader, Communicable Disease Prevention and Response, BCCDC

—Hannah M. Baer, PhD
Epidemiologist, Communicable Disease Prevention and Response, BCCDC

—Kirsty Bobrow, MBChB, DPhil, MSc
Medical Director, Communicable Disease Prevention and Response, BCCDC

—Barbra Arnold, MD, CCFP
Physician, Communicable Disease Prevention and Response, BCCDC

—Rochelle Stimpson, MD, CCFP
Physician, Communicable Disease Prevention and Response, BCCDC

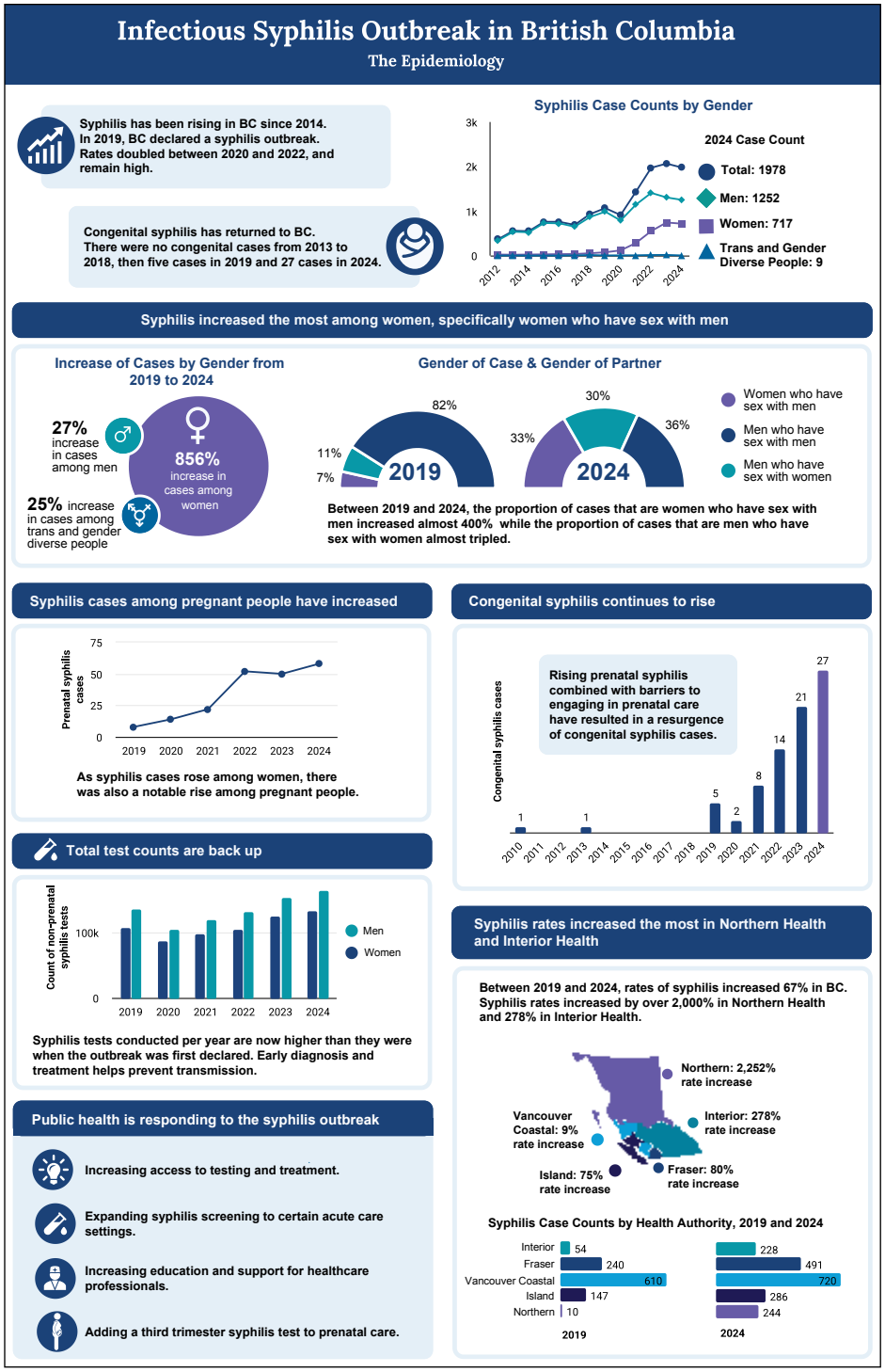

FIGURE. The infographic created to summarize key findings from the syphilis outbreak in BC in 2019.

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BC Crisis Line: 310-6789
(no area code needed, available 24/7 across BC)

Who it's for: Anyone in BC

Additional resources in BC:

1-800-SUICIDE (1-800-784-2433) is the BC suicide prevention and intervention phone line.

9-8-8 is the national suicide crisis phone and text line.

Obituaries

We welcome original tributes of less than 700 words; we may edit them for clarity and length. Email obituaries to journal@doctorsofbc.ca. Include birth and death dates, full name and name deceased was best known by, key hospital and professional affiliations, relevant biographical data, and a high-resolution head-and-shoulders photo.

Dr Shunmoogam "Willie" Wolaganathan Pillay

1941–2025

It is with profound sadness that we announce the passing of Dr Shunmoogam "Willie" Wolaganathan Pillay on 10 November 2025, at the age of 84. Willie was a devoted father, physician, and community leader, and his life was a testament to resilience and unwavering commitment to others.

Willie was predeceased by his parents, Meenachee and Kisten Shunmoogam Pillay, and two brothers, Krish and Parmas Pillay. He is survived by another brother, Praga Pillay; his sisters, Uga Nichols (Pillay) and Nat Moodley; his children, Simon, Mark, and Soraya Pillay; his grandchildren, Stephen and Katherine Pillay; and many nephews and nieces living abroad.

Born in Durban, South Africa, on 17 August 1941, Willie came from a prominent family in Greenwood Park, a close-knit Indian–South African community. His early years were marked by both privilege and hardship. After losing his parents at a young age, he stepped into a leadership role early in life, a responsibility that shaped his character and became a defining thread throughout his life.

Willie was deeply engaged in the struggle against apartheid. His activism was not a passing phase but a lifelong conviction. The government's crackdown on student leaders forced Willie to leave his homeland and seek a future abroad. He chose Ireland, a country whose own history of struggle resonated deeply with him.

In Dublin, Willie pursued medical training at the Royal College of Physicians of Ireland. He embraced Irish culture wholeheartedly, to the extent that friends often joked he knew more about Ireland than many native Irish people. His years there were marked by rigorous study, enduring friendships, and a zest for life. In 1969, he met Margaret, who would become his wife.

In 1972, Willie and Margaret immigrated to Canada, where Willie specialized in internal medicine. They married in 1975 and began building a family, welcoming their first child, Simon, in 1976. They eventually put down roots in Moose Jaw, Saskatchewan, where their family grew with the births of Mark and Soraya.

For more than 2 decades, Willie served as a respected physician and community leader in Moose Jaw. He built a thriving medical practice, earned admiration as a cardiologist, and held key positions, including chief of staff and medical director. Willie chaired the Canada Day Committee; championed civic initiatives; and opened his home for gatherings that brought together neighbors, colleagues, and the Sisters of Providence of St. Vincent de Paul.

The Sisters of Providence, a Catholic congregation, had a long-standing mission to serve society's most vulnerable. Willie found in them kindred spirits and became one of their most trusted partners.

Willie's passion for eldercare became a defining chapter of his career. In the early 1980s, he proposed replacing an outdated hospital with a modern, integrated approach. At age 50, Willie returned to school to specialize in geriatrics, a testament to his determination. For 15 years, he worked tirelessly alongside the Sisters of Providence and government partners to bring this dream to life. In 1995, their shared vision was realized with the opening of Providence Place for Holistic Health, a state-of-the-art facility that transformed eldercare in the region.

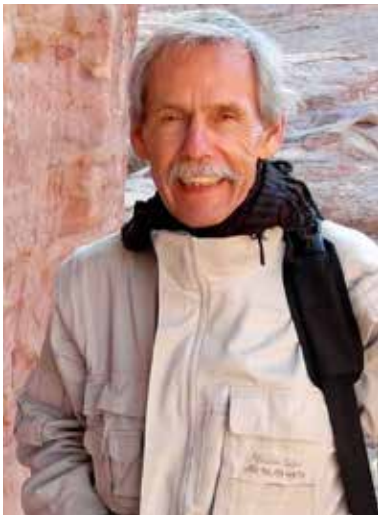
In 1996, Willie relocated to Surrey, where he continued his work as a geriatrician in private practice and the first staff geriatrician at Surrey Memorial Hospital. His expertise was widely recognized. He served as president of medical staff, chief of geriatrics, and a key interest holder and expert panel member for the Fraser Health Authority's Code Plus initiative, which focused on elder-friendly hospital design and improved geriatric care. Willie continued practising medicine until 2016, reluctantly stepping back when illness made it impossible to continue.

From 2017 onward, Willie himself lived in care homes, facing complex medical challenges with courage. His instinct to nurture and guide never faded but rather was taken by illness, despite a relentless battle against this inevitability.

A funeral service celebrating Dr Pillay's life was held on 29 November 2025 at Victory Memorial Park & Funeral Centre in Surrey. In lieu of flowers, the family invites donations to CanAge (www.canage.ca/donate),

Canada's leading independent advocacy organization dedicated to raising standards in eldercare, preventing abuse and neglect, and ensuring dignity for seniors in long-term care and beyond. ■

—Krishnan Simon Pillay
Ottawa



Dr Andrew Farquhar
1947–2025

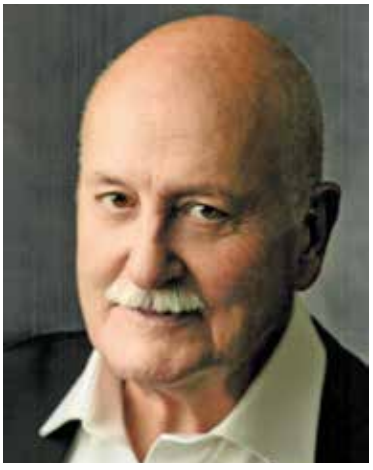
Dearly loved husband, father, grandfather, friend, and physician, Dr Andrew Farquhar has completed the adventure of a life lived to the fullest.

Dr Farquhar was born in Scotland, where he spent a carefree childhood with his sister, Margaret, and brothers, John and David. Diagnosed with type 1 diabetes at a young age, Andrew was determined to make the most of every day. He excelled at whatever he turned his hand to, whether as captain of the rugby team at school, winning the class medal at Edinburgh Medical School, or achieving international recognition as a photographer with a cover photo for a *National Geographic* calendar. His unique perspective, combining personal experience and clinical expertise in diabetes, made him invaluable locally and sought after internationally as an educator and guest speaker. He was remarkably kind and will be best remembered for his genuine nature, his sense of humor, and his ability to connect with everyone.

His greatest love was his family—his wife Stephanie, with whom he shared over 50 years of adventures; his daughter Jaclyn (Deke) and their daughter, Eberly; and his daughter Vanessa (Aaron) and their sons, Shepherd and Arlo.

A celebration of life was held at Springfield Funeral Home in Kelowna on 14 November 2025. In lieu of flowers, please consider donating to Breakthrough T1D Canada in Andrew's name to support diabetes research (https://breakthrought1d.ca).

—Stephanie Hayden
Kelowna



Dr David Gilmore Hunt
1944–2025

Dr David G. Hunt died on Thursday, 30 October 2025, as a result of an overwhelming chest infection and pulmonary fibrosis.

David, the youngest of four boys, was born in Victoria on 15 March 1944 to Jean and Leigh Hunt, where Leigh was in the army. The family returned to Vancouver in 1945, where David attended Prince of Wales Elementary and High School, graduating as school president in 1962. The school's motto remains *Ich Dien* ("I serve"), and it embodies David's entire life. He entered the University of British Columbia and followed in his father's and two older brothers' footsteps, choosing a career in medicine.

His postgraduate training began in 1969 in Toronto, after which he practised medicine for over 50 years with passion, empathy, and, above all, a sense of humor. His career had three phases, the first being emergency medicine, where he received a fellowship.

Returning to Vancouver, David worked in the Vancouver General Hospital emergency department and devoted many volunteer hours to creating the paramedic program, including the publication of the *Handbook of Industrial First Aid*. Following his time as an on-call emergency physician, David joined the Workers' Compensation Board medical team, where he ran the Business and Employer Emergency Preparedness (BEEP) program—a revolutionary approach to integrate injured workers for early return to work.

David completed a graduate program in pain management at the University of California, San Francisco, which enabled him to enter his second phase of medical practice by joining the St. Paul's Hospital Complex Pain Centre. Then he had more time to connect with his patients, forming strong bonds of support and compassion.

David's work in complex chronic pain and his service with Pain BC and the BC Hospice Palliative Care Association earned him recognition in the field that led him to his final career phase: a palliative care practice at Lions Gate Hospital.

He was an active member of the Sovereign Order of St. John of Jerusalem for over 15 years, serving as commander of the local chapter and advocating passionately for its work in the palliative care sector. He was a longtime supporter of the Lumara Society, Doctors Without Borders, and the Salvation Army. He was also awarded Doctors of BC's 2025 Silver Medal of Service.

David's life was not all work and no play. He loved parties; fishing; hunting in the Cariboo; skiing at Whistler; bike trips; walking his faithful labradoodle, Sophie; and boating, particularly to Centre Bay Yacht Station as skipper of *Piccolo*.

David's signature presentation, and his strong belief, was that laughter is the best medicine.

Family was always at the centre of David's life, and he spoke often and lovingly of his

Continued on page 44

2025 J.H. MacDermot writing prize winners

Ms Stephanie Quon is the winner of the J.H. MacDermot Prize for Excellence in Medical Journalism (Independent), which recognizes a BC medical student's significant achievement in writing an article without any physician coauthors, for her article "Witnessing the in-between."

Ms Quon is a second-year medical student at the University of British Columbia, in the Vancouver program. She previously completed a degree in electrical engineering and is interested in health care accessibility and health equity. Ms Quon is co-president of the UBC Refugee Health Initiative, Women's Health Initiative, and Correctional Health Initiative, and founder of the Canadian Network for Accessibility in Healthcare. She was inspired to write "Witnessing the in-between" following her participation in the Making a Legacy Palliative Care Project, where she was paired with an individual who was receiving end-of-life care to create a legacy piece.

Ms Lucy Hui is the winner of the J.H. MacDermot Prize for Excellence in Medical Journalism (Mentored), which recognizes a BC medical student's significant achievement in medical writing as part of an author team that includes physicians, for her article "Artificial intelligence in family medicine: Opportunities, impacts, and challenges."

Ms Hui is a third-year medical student at UBC with an interest in the responsible integration of emerging technologies into clinical practice. Under the guidance of Dr Rohit Singla, her work explored the practical use of artificial intelligence in primary care, with attention to its effects on clinical workflows and patient care. Ms Hui has also contributed to initiatives aimed at improving data science literacy among medical trainees and encouraging thoughtful engagement with the ethical and equity-related challenges of new technologies. Looking ahead, she hopes to continue engaging in work that explores how technology can support clinicians and strengthen health care delivery, particularly in community-based, rural, and underserved settings.

The *BCMJ* welcomes article submissions from BC medical students and offers these prizes for the best submissions accepted for publication. A winning article for each prize is selected from all eligible articles published in a calendar year. For more information about the prizes, visit https://bcmj.org/about/writing-prizes-medical-students.

OBITUARIES

Continued from page 43

deceased grandparents and parents. He was predeceased by two older brothers, John, the eldest, and his infant brother, Andrew, from sudden infant death syndrome. He is survived by his next-older brother, Brian.

David will be sadly missed by many friends and family members: his wife, Carol Kerfoot; his sons, Simon, Cameron, and Peter; his brother, Brian (Barbara); his sister-in-law, Beverly (John); his former wife, Dr Elaine Drysdale; Carol's children, Joy, Michael, and Sylvia Kerfoot (Harrison); and his grandchildren, Emily, Madeline, Gabriella, Juliana, Charlie, Hannah, Ollie, and Natalie.

In lieu of flowers, please donate to a charity whose goals align with yours. And have a good long laugh for David; it's what he would have wanted.

—Carol Kerfoot
Vancouver

—Brian Hunt, MD
North Vancouver

JCC

Continued from page 39

ICU coverage, easing the on-call burden for intensivists. Clinicians report positive experiences, with emergency physicians gaining valuable ICU exposure and intensivists welcoming the added support and relief.

Several programs focus on building physician skills and capacity in rural emergency departments. The Emergency Education Program, funded by the JSC and delivered in partnership with RCCbc and the Rural Education Action Plan (REAP), offers family physicians a 3-month, full-time, remunerated fellowship in emergency medicine at sites across the province. Participants gain advanced clinical, procedural, and leadership skills, enabling them to serve as emergency care leaders in their home communities.

For physicians preparing for or returning to rural practice, the Rural Skills Upgrade Program, also funded by the JSC and administered by REAP, provides up to 20 days of one-on-one preceptorship in training areas including emergency medicine, obstetrics, oncology, mental health, and Indigenous health.

Recognizing the physical and emotional impact of critical incidents, the Isolated Medical Provider Aftercare Team, funded by the JSC and administered by RCCbc, offers confidential peer-to-peer support from experienced rural clinicians, with connections typically made within 72 hours.

Collectively, these complementary initiatives strengthen rural emergency care by meeting physicians where they are—clinically, geographically, and emotionally—ensuring that high-quality emergency care remains available close to home.

For more information on these initiatives, please visit the respective organizations' websites. ■

—James Card, MD
Family Physician, Valemount
Co-Chair, Joint Standing Committee on Rural Issues

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A quick pivot

From holiday disaster to coastal hiking magic.

Niall Davidson, MD, Leigh Trusler, BA, BEd

With an open road ahead of us and a blue sky above, we headed out for a rejuvenating week away from our neurology practice. A road trip, hiking, and restful solitude were exactly what we needed.

On the drive to Vancouver, we kept one eye on the unfolding news of a wildfire burning near Squamish—very close to the area we planned to hike—and the other eye on our falling tire pressure gauge.

The next morning, it was clear we needed our now totally flat tire checked, and the repair shop showed us the large nail lodged in our tire tread. A new tire was ordered and installed, the delay giving us time to do a deep dive into the FireSmoke Canada website, which showed that our hiking destination was covered in a thick pall of Squamish wildfire smoke.

Looking at each other, we considered our options. Since exercising in smoke is not advised, we smiled and headed bravely for the ferry with no reservations (a debatable move) but our fingers crossed. It was Friday the 13th, but could our luck finally begin to change?

One day and several phone calls later, we found ourselves—backpacks loaded—waiting for a water taxi in Tofino, ready for what was ahead. Our boat driver expertly maneuvered out of the boat launch area, past the crab fishers, and into the open ocean. Salt spray whipped our faces as we raced past emerald-green islands and rocky shores dotted with the occasional beach. We slowed at Flores Island, the beautiful village of Ahousat glittering distantly on the horizon.

After thanking our driver (and reminding him to pick us up in a few days), we stepped onto a white-sand beach and onto the Wild Side Trail. We were hit with the smells of cedar, salt, moss, and cool air, and then, finally, with the quiet.

We marveled at the towering cedars and the soft soil under our hiking shoes. The sound of the ocean was never far. Finally, the trail gave way to clusters of salal, sweet-scented wild rose, and stunning Whitesand Cove, where we decided to camp for the night. At the end of our lovely day, some porpoises dipped and dove in the waves in front of our tent site.

There was no fresh water at the campsite. The water source marked on the map had long since dried up. In the morning, we hit the trail with the few litres of water we had left, which, thankfully, were just enough. We soon came to a river and hiked along its banks, tasting the water until we no longer detected salt from the ocean. The water was cool and fresh. We filtered it, filled our bottles, and carried on.

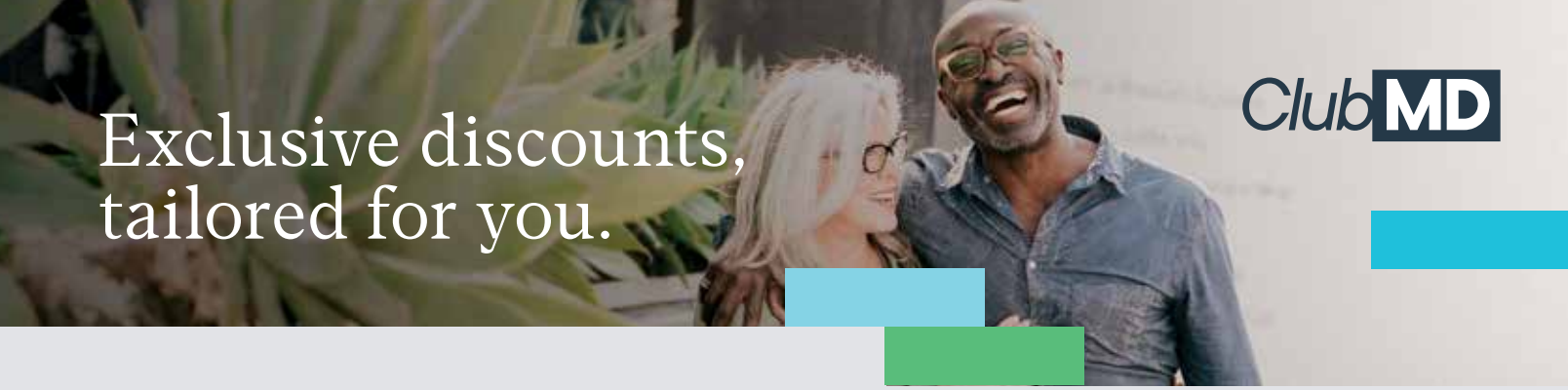
Eventually, the Wild Side Trail led to beautiful Cow Bay, its access marked with colorful buoys hanging in a tree with happy yellow tansies below. Cow Bay's beauty is unparallelled. Imagine a white-sand Caribbean crescent beach with pines instead of palms.

We set up camp and headed to the river—darker, cooler, and even tastier than our previous water stop. Our night was complete with a beautiful sunset. We laughed and reflected on our quick pivot from trip failure to success. The forest fire and the nail in our tire seemed like distant memories. And yes, the water taxi driver remembered to pick us up the next morning. ■

Dr Davidson is a neurologist in the Okanagan Valley. Ms Trusler, Dr Davidson's wife, runs the practice. When not at work, they can be found exploring the beauty BC has to offer, sometimes amid a few obstacles.

The 11 km Wild Side Trail on Flores Island is a rare and beautiful gem worthy of gentle exploration. Before you go:

- Get your permit and pay the Ahousaht Hahoulthee Access Fee.
- Book your water taxi for drop-off and pickup.
- Take enough water, and ensure you understand where the water sources are.
- Be prepared to be self-sufficient.
- Bring your own toilet paper for the campsite pit toilets.
- Practise leave-no-trace camping and hiking—garbage in, garbage out.



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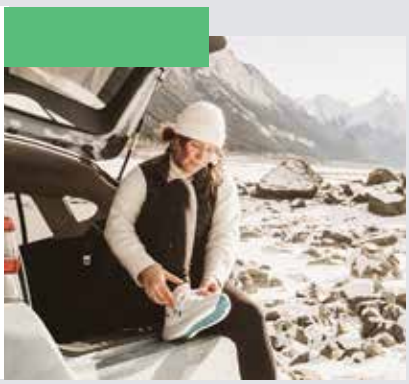

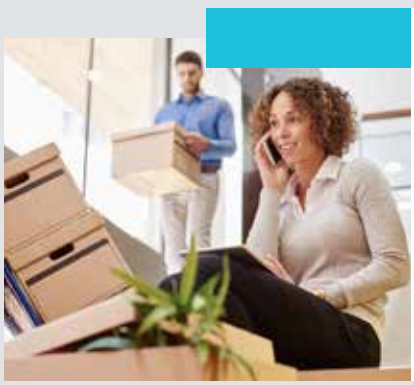

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