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.

Re: Failing health care delivery in Canada is the result of an outdated operating model

I read Dr Tevaarwerk's article [*BCMJ* 2025;67:359-364] with interest. I'm a family physician (GP from the UK, really) who moved to Canada 3 years ago. I worked in National Health Service (NHS) management and strategy for several years, and I have a PhD in epidemiology, so how different health systems work is of great interest to me. I don't know much about the Dutch health system, but of course I know a great deal about the UK's NHS, and I have studied other systems. I don't think the Canadian system (or the British Columbian system, specifically) is actually that similar to the UK's, and I don't think "command and control" is that good of a description of the BC system, certainly not compared with the NHS. It would be more accurate to describe the NHS as a highly centralized commissioner–provider system. Canada has a much more federated system (like Germany), which works to its advantage. Yes, it's also commissioner–provider, but that's not command and control—it seems designed to allow more flexibility in the system to account for huge geographic and population differences. There's very little command or control over the primary care system, which doesn't even require family physicians to attach all patients who apply (as is required in the UK, which is why it has universal GP coverage).

I would also have thought that a major difference between the Dutch and Canadian systems is the massive geographic and population challenges, such as the fact that Canada is more than 200 times the size of the Netherlands. Providing anything resembling universal health care across such a wide area and variable population is always going to be much more expensive.

The Netherlands does indeed generally outperform Canada in health care, but it isn't a huge difference by any means, as seen in the *Mirror, Mirror 2024* report from the Commonwealth Fund.[1] For what it's worth, Canada even slightly outperforms the Netherlands in reducing mortality and administrative barriers to care.

From what I've seen, the Canadian system (at least in BC) isn't perfect by any means, but it continues to get a lot of things right and is noticeably more sustainable and robust than the one I left in the UK. I'm sure it can improve, and better integration is certainly one way it could, but I don't think paying doctors more is particularly part of the answer.

—Paul Park, MB, BChir, MRCGP
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Reference

1. Blumenthal D, Gumas ED, Shah A, et al. Mirror, Mirror 2024: A portrait of the failing U.S. health system. 19 September 2024. Accessed 19 December 2025. www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024.

Re: Presentation of pediatric cannabis ingestion in the emergency department

We read with interest the recently published article "Presentation of pediatric cannabis ingestion in the emergency department" by Sage and colleagues[1] and commend the authors for this important work. It highlights important information on the increasing prevalence of emergency department (ED) visits due to exploratory ingestions of and pediatric exposure to edible cannabis products in Canada. It also discusses the importance of prevention as a primary strategy for reducing the availability of these products to young children, including implementing strict package warnings, labeling standards, and promotional limitations, thereby reducing pediatric cannabis exposures.[1]

Tackling the packaging of edibles as a preventive strategy to reduce cannabis exposure in young children is an important aspect of this public issue in North America. Many labels used for cannabis products include bright, colorful figures and are highly attractive to young children exploring their environments. Moreover, much of the packaging is made to resemble popular non-cannabis-containing candy and snacks, further increasing children's risk for consumption. Reducing the recognizability of packages using labeling standards and plain materials and design are critical tools that could reduce children's exposure to cannabis ingestion.

Another important area for prevention of harm is regulating the amount of cannabis contained in one packaged edible. Sage and colleagues report that there is no exact dose–response relationship for cannabis, but oral bioavailability of tetrahydrocannabinol (THC) is higher in children than in adults.[1] This difference in the clinical pharmacological properties of THC among children has been reported with the increase in severe toxicity cases, resulting in more ED visits and pediatric ICU admissions following the legalization of marijuana.[2] Many edibles are packaged with multiple "doses" in each package, and children who accidentally ingest the edible are at risk of consuming the entire product, when the intent is for

the product to be rationed into distinct "doses." As an example, a single square of chocolate or a single gummy may contain one "dose," but a package can contain an entire chocolate bar or several handfuls of gummies. Some packages of edibles contain up to 500 mg of THC, a highly toxic dose for children, since 100 mg of THC is considered a very high dose for an adult.[3]

We agree that pediatricians have an important role in counseling families about safe storage of edibles at home, but without increased public health attention and legislative drive, preventable ingestions will continue. Packaging that is not visually appealing to children and childproofing are two critical methods of reducing pediatric exposure to marijuana and visits to the ED for symptoms of toxicity.

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—Ran D. Goldman, MD, FRCPC
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—David Greenky, MD
Atlanta, Georgia

References

1. Sage AP, Alahmadi M, Sabhaney V, et al. Presentation of pediatric cannabis ingestion in the emergency department. BCMJ 2025;67:318-323.
2. Tweet MS, Nemanich A, Wahl M. Pediatric edible cannabis exposures and acute toxicity: 2017–2021. Pediatrics 2023;151:e2022057761. https://doi.org/10.1542/peds.2022-057761.
3. Smart Approaches to Marijuana Minnesota. Edibles dosage. Accessed 21 December 2025. www.house.mn.gov/comm/docs/Xwf3qfOrtkSk7L4QdZVdUA.pdf.

Re: Ethical considerations around the use of artificial intelligence in health care

Studies have shown that critical reasoning atrophies when using artificial intelligence (AI), even if the intent is to be diligent.[1] Microsoft has confirmed this finding.[2] Deep knowledge of statistics and computers is not needed to understand the negative impact of AI on cognitive abilities.[3]

It doesn't matter how well you prompt a chat bot; it will still get a staggering number of answers wrong. The example prompt offered in the article ["I am a family physician in Vancouver. What is the best antihypertensive medication for my 55-year-old Indigenous patient with comorbidities including heart failure and chronic kidney disease? Search PubMed for relevant publications and provide references for your answer. Select medications covered by non-insured health benefits."], like any similar prompt, is subject to which medication has the most aggressive marketing in the data set. This assumes the data set is not limited to peer-reviewed articles, with all conflicts of interest accounted for.

A "good prompt" should consider the risk of violating patient privacy and confidentiality, promote transparency, and meet professional standards of practice.[4]

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This letter was submitted in response to the COHP article in the November issue of the BCMJ *(2025;67:326,328).* –Ed

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6. CEIC. Canada CA: Hospital beds: Per 1000 people. Accessed 1 February 2026. www.ceicdata.com/en/canada/social-health-statistics/ca-hospital-beds-per-1000-people.
7. Webster P. Canada's family physician shortage. Lancet 2024;403(10441):P2278. https://doi.org/10.1016/S0140-6736(24)01036-5.
8. Glazier RH. Addressing unmet need for primary care in Canada. Healthc Manage Forum 2024;37:451-456. https://doi.org/10.1177/08404704241271141.
9. Glynn T. Health Coalition shocked to learn health care left out of national leaders' debate. Canadian Health Coalition. 16 April 2025. Accessed 1 February 2026. www.healthcoalition.ca/health-coalition-shocked-to-learn-health-care-left-out-of-national-leaders-debate/.
10. Canadian Nurses Association. Federal parties largely silent on health care as top issue for Canadians, says CNA [news release]. 17 April 2025. Accessed 1 February 2026. www.cna-aiic.ca/en/blogs/cn-content/2025/04/17/federal-parties-largely-silent-on-health-care.
11. Canadian Medical Association. 2025 federal election. The CMA's policy recommendations. March 2025. Accessed 1 February 2026. https://digitallibrary.cma.ca/link/digitallibrary879.
12. Dellplain M. How health care works in Canada: What to know ahead of the 2025 federal election. Healthy Debate. 9 April 2025. Accessed 1 February 2026. https://healthydebate.ca/2025/04/topic/health-care-canada-federal-election/.
13. Ho K, Novak Lauscher H, Stewart K, et al. Integration of virtual physician visits into a provincial 8-1-1 health information telephone service during the COVID-19 pandemic: A descriptive study of HealthLink BC Emergency iDoctor-in-assistance (HEiDi). CMAJ Open 2021;9:E635-E641. https://doi.org/10.9778/cmajo.20200265.
14. Ho K, Pawlovich J, Berg S, et al. Real-Time Virtual Support: A network of virtual care for rural, remote, First Nations, and pan-provincial communities in British Columbia. CMAJ 2025;197:E754-E758. https://doi.org/10.1503/cmaj.240908.
15. Island Health. Local health area profile: Alberni-Clayoquot – 426. February 2025. Accessed 1 February 2026. www.islandhealth.ca/sites/default/files/communications/lha%20profiles/alberni-clayoquot-lha-profile.pdf.
16. Health Canada. Working together to improve health care in Canada: Working together bilateral agreements. Modified 20 January 2026. Accessed 1 February 2026. www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities/working-together-bilateral-agreements.html.
17. Health Data Coalition. Accessed 1 February 2026. https://hdcbc.ca/.

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References

1. Kosmyna N, Hauptmann E, Yuan YT, et al. Your brain on ChatGPT: Accumulation of cognitive debt when using an AI assistant for essay writing task. arXiv. 10 June 2025. Accessed 18 December 2025. https://arxiv.org/abs/2506.08872.
2. Lee H-P (H), Sarkar A, Tankelevitch L, et al. The impact of generative AI on critical thinking: Self-reported reductions in cognitive effort and confidence effects from a survey of knowledge workers. CHI '25: Proceedings of the 2025 CHI Conference on Human Factors in Computing Systems. 25 April 2025. https://doi.org/10.1145/3706598.3713778.
3. Roxin I. Generative AI: The risk of cognitive atrophy. 3 July 2025. Accessed 18 December 2025. www.polytechnique-insights.com/en/columns/neuroscience/generative-ai-the-risk-of-cognitive-atrophy/.
4. College of Physicians and Surgeons of British Columbia. Ethical principles for artificial intelligence in medicine. Revised 3 October 2024. Accessed 18 December 2025. www.cpsbc.ca/files/pdf/IG-Artificial-Intelligence-in-Medicine.pdf.