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.

Holistic medicine—Benefits for the physician and the patient

Being a long-time supporter of holism in medicine, I was pleased to read the editorial on holistic Indigenous medicine[1] but was chagrined to read the article about our pediatrician colleagues' struggles with pediatric mental health.[2] The editorial on Indigenous health spoke of a proud and empowered re-emergence into a larger, more inclusive Two-Eyed Seeing medical model. Pediatricians, on the other hand, seem to be sinking into heartbreak and dispiritedness. Would more helpers be the solution? Who could afford them? I think that as heartfelt practitioners, we are all stymied at this point. What will this 60% of the pediatrician population look like in 10 to 15 years? Who will family physicians be seeing in their offices?

Most Indigenous medicine philosophies (e.g., First Nations, Taoist, Vedic, Tibetan) are wisdom based and holistic. They originate from a nondual experience of reality. From that point of view, the world is sacred, interconnected, friendly (i.e., discerning but not against), and generous (i.e., basically good). What if medical students were continuously exposed to and tutored in this path of self-cultivation (i.e., "Physician, heal thyself"; e.g., Ken Wilber's integral theory to grow up, clean up, wake up, and show up, or other traditional models found in tantra, shamanism, etc.) alongside their traditional Western training? It boggles the mind! Yet, marinating in this Two-Eyed Seeing approach for 6+ years might strengthen young physicians, giving them resilience and humor—the heart and the spirit we are seeking—and enabling them to stand in the chaos of suffering and proclaim "I am the doctor and I am the medicine."

—Jim Tucker, MD
Victoria

References

1. Aldred T. Traditional medicines and healing practices. BCMJ 2026;68:6-7.
2. Schrewe B, Tsai S, Evoy B. Community-based consultant pediatrician perspectives on child and youth mental health in British Columbia. BCMJ 2026;68:29-35.

The Health Professions and Occupations Act makes a health care system built on trust, respect, and collaboration less achievable

I'm a physician practising in British Columbia, and, for the first time in my career, I find myself questioning whether this profession is still worth it.

When I chose medicine, I believed it was a calling. I grew up watching my father (also a physician) dedicate himself to our community. He worked long hours helping people through the most difficult moments of their lives, sacrificing his sleep, his weekends, and time with our family. Yet he was valued, trusted, and respected for it. This example shaped my life. I have spent over a decade in university and put my family into hundreds of thousands of dollars of debt to serve my community in the same way.

Today, however, the relationship between physicians and the health care system is eroding. The Health Professions and Occupations Act (HPOA) reinforces the message that physicians are adversaries who must be controlled and punished, rather than professionals who should be trusted and supported. Many of the changes imposed by the HPOA weren't openly discussed with physicians, or even patients. Among other things, the HPOA replaces elected College of Physicians and Surgeons of British Columbia representatives with government appointees. It then allows these appointees to impose fines or even seek imprisonment for infractions. It removes meaningful appeal processes and expands bureaucratic oversight. It allows appointees to access medical records without a court order. It seems to suggest that individual physicians, rather than overburdened and mismanaged systems, are the problem with our health care system. To many physicians, this does not feel like reform; it feels like mistrust.

This sentiment is particularly painful given what we have been asked to endure in recent years. During the pandemic, physicians stepped forward when our communities needed us most. We accepted reassignments to high-risk environments, jeopardizing our personal safety to protect the public. I contracted COVID-19 while reassigned to a critical-care ward and passed it on to my family before vaccines were available.

We accepted these risks because we believed that medicine was a calling, and we honored the trust placed in us. Now it feels like that trust has been eroded.

The reality is that practising medicine in BC is already difficult. Physicians are not employees, but independent contractors. We are responsible for our clinic rent, staff salaries, medical equipment, and supplies. We have no paid vacation, sick leave, or health care benefits. Furthermore, we are not protected by the Employment Standards Act or WorkSafeBC. We may work

28 to 72 hours at a time without protected breaks to eat or sleep.

Despite this, many of us stay in medicine, because the work matters. However, legislation like the HPOA threatens to break our commitment. When the system treats physicians like potential offenders rather than partners in care, it creates moral injury. It signals that dedication, sacrifice, and expertise are not valued.

At a time when BC is facing physician shortages, discouraging physicians seems counterproductive. If the work becomes riskier and less valued, many physicians will leave. Speaking as both a physician and a patient, I want a health care system built on trust, respect, and collaboration. But I believe that legislation like the HPOA makes this less achievable.

—A. Vallee, MA, MD
Victoria

Medical students' perspectives on long-term care

As second-year medical students, we visited a local long-term care home and witnessed the challenges faced by both residents and staff. Conversations with residents deepened our understanding of their daily lives and the essential role these facilities play, while discussions with staff highlighted the strain placed on the system by limited resources and a lack of physician availability. One resident shared that they had waited nearly 2 years for placement. While Canada's physician shortage is well documented, experiences like this reflect a broader issue: growing demand for long-term care is outpacing the system's capacity to provide it.

By 2028, more than one-fifth of Canada's population will be over 65 years of age, intensifying demand for long-term care services.[1] In British Columbia, the number of publicly subsidized long-term care beds per 1000 adults 75 years of age and older has fallen from 77 beds in 2015–2016 to 58 beds in 2024–2025, indicating a widening gap between demand and available care.[2] At the same time, the number of people waiting for long-term care has more than tripled, rising from 2381 individuals in 2016 to 7212 in 2025.[2]

These delays have consequences beyond the long-term care sector. Many seniors who require long-term care remain in hospital beds while awaiting placement, classified as alternate-level-of-care patients. In BC, seniors account for 80% of alternate-level-of-care cases, underscoring the close link between alternate-level-of-care shortages and hospital overcrowding.[2] Prolonged hospital stays can contribute to poorer health outcomes for older adults, including functional decline, increased infection risk, and worsening mental health, while simultaneously limiting access to acute care beds for others.

Workforce shortages further compound these system pressures. Long-term care residents often have complex medical needs that require consistent physician oversight. However, many facilities struggle to recruit and retain physicians willing to practise in long-term care settings. Administrative demands, travel between facilities, and on-call responsibilities can make long-term care practice difficult to sustain, particularly in the broader context of family physician shortages.[3]

Encouragingly, BC has introduced initiatives through the Family Practice Services Committee to support the long-term care physician workforce. The Long-Term Care Initiative provides funding for after-hours availability, quality improvement, and compensation for physicians serving as most-responsible providers.[4] Together, these measures aim to strengthen continuity of care, support clinicians, and reduce unnecessary hospital transfers.

As medical learners, we believe that increasing exposure to long-term care during training may help address this challenge. Early and meaningful engagement in long-term care settings can foster clinical competence, empathy, and a deeper understanding of the needs of older adults. Expanding clinical placements and elective opportunities within long-term care could encourage more trainees to consider careers caring for this vulnerable population.

Ensuring timely access to long-term care is essential, not only for the well-being and dignity of older adults, but also for the resilience of the health care system. Addressing long-term care capacity, workforce support, and training opportunities will be critical as Canada prepares for the growing demands of an aging population.

—Ava Hughes, BSc
—Raha Masoudi, BSc
—Ava Cornell, BSc
—Savannah Swann, MSc
Medical Students, University of British Columbia Faculty of Medicine

References

1. Gibbard R. Meeting the care needs of Canada's aging population. Ottawa: Conference Board of Canada, 2018. Accessed 16 March 2026. www.cma.ca/sites/default/files/2018-11/Conference%20Board%20of%20Canada%20-%20Meeting%20the%20Care%20Needs%20of%20Canada%27s%20Aging%20Population%20%281%29.PDF.
2. Office of the Seniors Advocate BC. From shortfall to crisis: Growing demand for long-term care beds in B.C. Victoria, BC: Office of the Seniors Advocate BC, 2025. Accessed 16 March 2026. www.seniorsadvocatebc.ca/app/uploads/sites/4/2025/07/From-Shortfall-to-Crisis-Report.pdf.
3. College of Family Physicians of Canada, Canadian Society for Long-Term Care Medicine. Joint position statement on the role of family physicians in long-term care homes. Mississauga, ON: College of Family Physicians of Canada, 2021. Accessed 16 March 2026. www.cfpc.ca/CFPC/media/PDF/Role-Family-Physicians-Long-Term-Care-March-2021.pdf.
4. Family Practice Services Committee. Long-term care. Updated 16 December 2024. Accessed 16 March 2026. https://fpscbc.ca/what-we-do/clinical-supports/long-term-care.

EDITORIALS

References continued from page 122

4. British Columbia Ministry of Attorney General. Adopting permanent daylight saving time: 'Spring forward' on March 8 will be the last time change, ending twice-yearly clock changes [news release]. 2 March 2026. Accessed 15 March 2026. https://news.gov.bc.ca/releases/2026AG0013-000209.
5. Carman T. 'Scientifically not a good idea,' says researcher whose work informed B.C.'s daylight-time decision. CBC News. 5 March 2026. Accessed 15 March 2026. www.cbc.ca/news/canada/bc-daylight-saving-health-concerns-9.7114947.