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: The triple burden experienced by incarcerated people in British Columbia

I read with interest the article "The triple burden experienced by incarcerated people in British Columbia: Mental illness, substance abuse, and poverty" in the April 2026 issue of the *BCMJ*.[1] As a physician, this subject has troubled me for years. The unrecognized elephant in the room is fetal alcohol spectrum disorder (FASD). The prevalence of FASD in the incarcerated adult population is disproportionately high, with estimates ranging from 17.5% to 46% depending on the setting and population studied, compared with general population estimates of 2% to 5% in Canada.[2]

An estimated 98% of individuals with FASD in Canada remain undiagnosed or misdiagnosed, and testing wait times range from 1 month to 4.5 years.[3] The barriers to diagnosis and treatment are overwhelming.

The estimated cost of a comprehensive FASD diagnostic assessment in Canada, as of 2013, was $3110 to $4570.[3] The cost of social welfare benefits for a person with a lifelong mental disability pension in BC is about $20 000 per year.[4,5]

The average cost per male prisoner in federal prison in 2020 was $126 000 per year; the average cost for women was 80% higher.[6]

One of my patients at a BC treatment centre was a pleasant, intelligent 35-year-old who had been in and out of prison since his mid-teens. He was an enforcer for a street gang. He thought he might have FASD, because he had trouble learning in school, he was illiterate, and his mother had alcohol use disorder. He asked me about FASD testing. He wanted to change his life, but the system was failing him. Upon release from prison, he attended Service BC as directed, where he was told to go to a computer and fill out forms for social assistance. He couldn't read, and he didn't know how to use a computer. Embarrassed, he left, and he again resorted to criminal behavior to survive and avoid homelessness. I explained to him that FASD testing was available but that it was expensive and not covered by the health care system. He didn't have the money. The cycle was destined to repeat itself indefinitely.

There are two reasons the federal and provincial governments need to provide FASD testing at no cost:

- Financial: Our governments are wasting taxpayers' money (i.e., spending $126 000 per prisoner for every year of incarceration versus approximately $5000 for a one-time FASD assessment and then $20 000 per year for social support).
- Legal: Universal access to health care in Canada is a fundamental tenet of our national and provincial health care systems. Citizens with FASD are being denied their rights.

What will change this unacceptable situation? Physicians putting strong pressure on politicians and our criminal justice system. There is no cure for FASD, but we can end the needless incarceration of citizens with FASD who have a lifelong disability through no fault of their own and who deserve timely assessment, kindness, and lifelong social support as first-line treatment, not incarceration.

—Murray Trusler, MD, MBA, FCFP, FRRMS
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Re: Commemorating 2 centuries since the death of the inventor of the stethoscope

Thank you, Dr Amir Dolatabadi, for an interesting article about the inventor of the stethoscope, René-Théophile-Hyacinthe Laennec [*BCMJ* 2026;68:93-95,109].

In the article, Dr Dolatabadi noted that Laennec was inspired to invent the stethoscope after observing children playing in the Louvre; one child struck one end of a long wooden stick while another placed their ear at the opposite end, successfully perceiving the transmitted sound. In his *Illustrated History of Medicine*, Jean-Charles Sournia gave further information about the discovery of transmitted sound perception. He stated that Laennec observed a group of children whispering along pipes on a building site in the Tuileries Garden, next to the Louvre.

Evidently, the young people of Paris should be doubly credited for the medical potential of child's play, perceived by Laennec on his strolls around the city.

It is sad, but unsurprising, that Laennec died an early death from tuberculosis, given that he spent his professional years using his invention to auscultate the chests of patients with respiratory symptoms, many of whom would have been suffering from consumption. His device could be regarded as responsible for his demise.

—Anthony Walter, MB BCh
Coldstream

Thanks to Dr Amir Dolatabadi for the article "Commemorating 2 centuries since the death of the inventor of the stethoscope" [*BCMJ* 2026;68:93-95,109]. It was an interesting and informative description of René-Théophile-Hyacinthe Laennec's life and times.

Over my long career as a physician, there have been changes in stethoscope technology and use. First, I was taught that, ideally, a stethoscope should be placed directly on the skin for the most accurate assessment of heart and lung sounds. While listening through thin clothing is possible—especially if the examiner applies firm pressure to negate sound attenuation—it can introduce artifacts and hide subtle, crucial sounds, reducing diagnostic quality. However, it appears that standard practice is now to place a stethoscope over one or sometimes two layers of clothing and to pronounce with confidence: "Your chest is clear." Single or double layers of light clothing can attenuate sound by 5 to 18 decibels.

Second, in 2000, Dr David Littmann introduced the electronic stethoscope. Electronic stethoscopes are generally considered better for detecting subtle sounds like soft murmurs due to superior amplification and active noise cancellation, especially in loud environments. They offer higher diagnostic accuracy and are advantageous for clinicians with hearing loss, for telehealth, and when assessing obese patients. As an emergency physician, I found an electronic stethoscope very useful in my often noisy surroundings.

I have two questions: (1) Why are doctors not applying stethoscopes to bare skin to maximize diagnostic accuracy? (2) Why are doctors not using electronic stethoscopes for better auditory performance, when so many of them are aging and their personal acoustic apparatus is failing?

Better use of the simple tools of clinical examination might reduce the spiraling costs of unnecessary imaging, speed up patient throughput, and reduce health care costs.

—Murray Trusler, MD, MBA, FCFP, FRRMS
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References continued from page 157

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