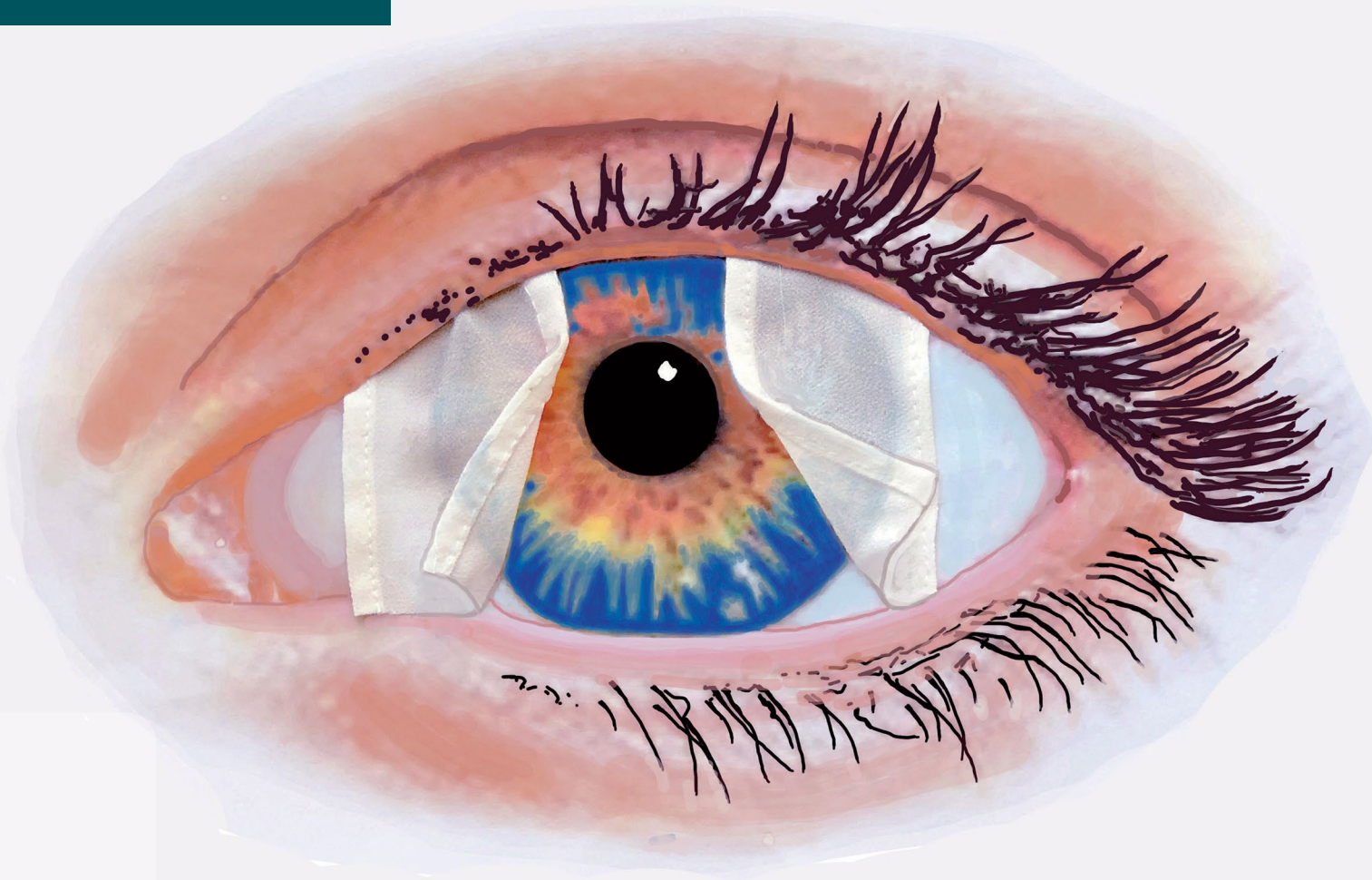


BCMj

A Doctors of BC Publication

Beyond the cloudy lens: A physician's guide to cataract treatment



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Assessing the generalizability of finerenone trial criteria to a British Columbia population with type 2 diabetes in a community endocrinology setting

A call for policy change: Funding fertility treatments for medical trainees

Patient portals and radiology reports: Toward patient-centred communication

Interview: Primary care is the focus of Simon Fraser University's new School of Medicine



Dr David Price (centre), dean of the Simon Fraser University School of Medicine, is proud of the relationships he and his team have built as they prepare to open Western Canada's first new medical school since 1950. "Primary care is the focus of Simon Fraser University's new School of Medicine" begins on page 196.

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

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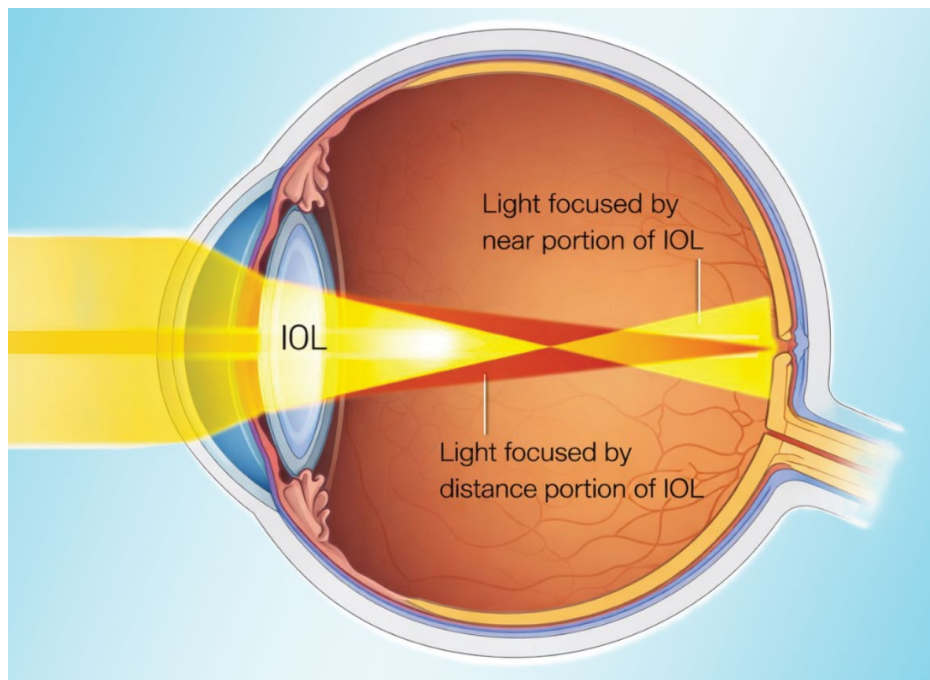
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For Doctors of BC, acknowledging the traditional territories is an expression of cultural humility that involves recognizing our
commitment to support the provision of culturally safe care to Indigenous Peoples in BC.

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The power of naming disease correctly: PCOS is now PMOS

A young woman presents with irregular periods, insulin resistance, hirsutism, and difficulty losing weight. She is told she might have polycystic ovary syndrome (PCOS). She leaves the clinic and, like many patients today, turns to the Internet for answers. She searches “ovarian cysts” and quickly becomes more anxious—reading about cyst rupture, surgery, and ovarian cancer. Eventually reassured that the cysts themselves are not dangerous, she accepts a prescription for oral contraceptives and moves on with her life. The irregular cycles improve, but the underlying metabolic dysfunction remains. Years later, she develops prediabetes and continues to struggle with her mental health and body image.

The diagnosis was correct. The name was not.

PCOS has now been renamed polyendocrine metabolic ovarian syndrome (PMOS). The change, introduced in *The Lancet* (May 2026) and spearheaded by Professor Helena Teede of Monash University in conjunction with international societies and patient groups, reflects a contemporary understanding of this highly prevalent condition.¹

The addition of “polyendocrine” and “metabolic” to the name signifies a paradigm shift that recognizes that PCOS has always been more than a disease of the ovaries. The new name is a clearer, more accurate description of the condition and incorporates the perspectives of clinicians and patients.²

PMOS affects 1 in 8 people with ovaries, making it the most common endocrinopathy in women of reproductive age. The emphasis on ovarian cysts likely came from its origin in 1935 as Stein-Leventhal Syndrome, after a series of women with amenorrhea and polycystic ovaries who

were diagnosed and treated via laparotomy.³ Although ultrasound findings of polycystic ovarian morphology became central to diagnosis in later decades, they do not represent the full pathophysiology of the condition.

The new name is a clearer, more accurate description of the condition.

The 2003 Rotterdam Criteria, which form the basis of the current diagnostic guideline, define PCOS/PMOS by two of three features:

- Oligo- or anovulation (cycles of less than 21 days or more than 35 days).
- Clinical or biochemical signs of hyperandrogenism.
- Polycystic ovaries (originally more than 12 follicles/ovary; updated in 2018 to more than 20 follicles/ovary due to improved ultrasound resolution).

Exclusion of other causes (e.g., Cushing syndrome, androgen-secreting neoplasms, congenital adrenal hyperplasia) is necessary.³

The most recent international evidence-based guideline for the assessment and management of PCOS⁴ continues to endorse the Rotterdam Criteria but does *not* require ultrasound evidence of polycystic ovarian morphology to establish the diagnosis. Elevated anti-Müllerian hormone (AMH) may be used in adults as an alternative to transvaginal ultrasound when assessing ovarian morphology. This is a welcome addition to the diagnostic framework, because AMH can be measured at any point in the menstrual cycle (~\$80 in BC; private pay) and is more accessible than specialized ultrasound. In adolescents (10–19 years of age), the diagnosis is made based on irregular cycles and hyperandrogenism.¹

The diagnostic algorithms developed through the international guideline process are freely available online and provide practical guidance on diagnosis, emotional well-being, lifestyle, pharmacological treatment for nonfertility indications, infertility, and PCOS and diabetes.⁵ Patient resources, including the AskPMOS app, are also available and can facilitate education and self-management.⁶

The new name—PMOS—better captures the full complexity of a condition involving insulin dysregulation, androgen excess, ovarian dysfunction, and neuroendocrine pathways. Its manifestations extend far beyond reproduction and include features that are:

- Metabolic (e.g., obesity, type 2 diabetes, cardiovascular disease, hypertension).
- Reproductive (e.g., infertility, endometrial cancer, pregnancy complications).
- Psychological (e.g., anxiety, depression, reduced quality of life).
- Dermatological (e.g., alopecia, acne, hirsutism).¹

One of the problems with the term PCOS is that it directs attention to a feature that is neither universal nor pathological. Although more than 20 small follicles—often referred to as “ovarian cysts”—may be seen on ultrasound in women with PMOS, these are a manifestation of disrupted ovulation, not the principal cause of the disorder. The updated nomenclature reminds us to focus on the patient rather than a single imaging finding and to prioritize prevention and management of the condition’s broader health consequences.

Medicine has a long history of misleading names. Heartburn does not involve the heart, ringworm is not caused by a worm, adults can get juvenile diabetes, German measles is not measles, and endometriosis

Continued on page 190

Access to specialists in BC: When you don't know what you don't know

As I doom scroll through my news feed, I begin to wonder who *isn't* on diversion. Is it pediatrics in the North, internal medicine/ICU on the Island, and obstetrics in the Interior? Or is it pediatrics in the Interior, internal medicine/ICU in Vancouver Coastal, and obstetrics in Fraser? “All of the above” got me through medical school, so that’s probably the right answer.

I check the call schedule. Neurology: blank. Respiriology: blank. Hematology: blank. Good thing I’m just a physician; I would hate to be a patient right now.

Over the last few years, we have seen a growing number of specialist service interruptions and closures across BC. It is often our rural communities that are first or disproportionately impacted. We saw rural ER and maternity diversions years before this became a common urban issue. Hospitals, health authorities, and call groups struggle to piece together services. Strategies have included incentives to attract locums, virtual care, and task shifting onto other specialists and primary care. When these fail, we take our sick, vulnerable patients and put them in an ambulance through a mountain pass or use expensive flight resources to transport them far from home. Diversions are bad for our patients, our health expenditures, and our carbon footprint.

To address the evolving specialist crisis, we must understand the magnitude of the problem. A Doctors of BC and Consultant Specialists of BC joint survey in 2024 estimated that 1.2 million BC residents are waiting for an outpatient specialist consultation.¹ This estimate was generated using self-reported data from approximately 900 specialists. As of 1 May 2026, there were 142 unfilled psychiatry postings on Health Match BC.² While a health services researcher may question using these

rudimentary measures to determine access to specialists, they would be hard-pressed to find good sources of data.

We need high-quality data on specialist distribution and wait times, intraprovincial referral patterns, and deferred care due to access limitations. Estimating specialist wait times at the provincial level is a daunting task, as there is minimal interconnectivity between EMR systems, and

We need a collaborative, data-driven approach to addressing gaps in specialist care.

there are numerous parallel referral paths, both within and across health authorities. This can lead to duplicate and unnecessary referrals and inefficient care. Pathways is an excellent resource containing specialist wait-time information, but these data are self-reported. EMR systems can be leveraged to report on wait times for individual specialists, likely by triage priority, but the process will be different depending on whether you use Med Access, Accuro, or one of the 15 or so other systems used in BC.³ Creating a standardized method to extract wait-time data across all EMR systems can be done, but if the responsibility to generate these reports is left in the hands of individual physicians, it will never happen.

The *Medical Services Plan Information Resource Manual: Fee-for-Service Payment Statistics* reports on physician numbers.⁴ For example, in 2024–2025, there were 103 fee-for-service otolaryngologists practising in BC. Of these, 45 were in Vancouver Coastal Health, and two were in Northern Health. This speaks to the supply, but what

about demand? Does Northern Health have 4% of the otolaryngology needs of Vancouver Coastal Health? The Canadian Institute for Health Information (CIHI) reports data on specialist counts by province.⁵ CIHI data are readily available and allow for comparisons to be made between provinces and territories, but the data often lag by years and do not include standards for what should be considered an acceptable distribution. We need benchmarks for acceptable access, and these will vary by specialty, subspecialty, subspecialty, and reason for referral.

We have some building blocks to understand the gaps in specialist access, but we need a better process to extract and analyze these data, and we need definitions of acceptable access. This shouldn’t be based exclusively on comparators with other regions and must reflect the access that is needed to support the health of our population. This necessitates a collaborative effort from physicians, the Ministry of Health, health authorities, allied health professionals, and patients. We have a shared responsibility to improve access to specialist care in BC.

We need a collaborative, data-driven approach to addressing gaps in specialist care. Once we fully understand the magnitude of the specialist access crisis in BC, we can stop using Band-Aids for bullet holes and develop a comprehensive provincial strategy to enhance access to specialist care. ■

—Denise Jaworsky, MD, PhD, FRCPC

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Specialists in BC *Continued from page 189*

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PMOS *Continued from page 188*

is not simply misplaced endometrial tissue. While these examples may seem amusing or harmless, terminology influences how patients understand their conditions.

A new name alone will not improve care and outcomes, but it will shift the conversation from ovarian cysts to a better appreciation of the multiple systems involved. PMOS is more than a new name; it is an opportunity to align our language with our science and ultimately improve the patient care we provide. ■

—Caitlin Dunne, MD, FRCSC

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Additional resources for women with PMOS from the Monash Centre for Health Research and Implementation: www.mchri.org.au/guidelines-resources/community/pmpos-resources-2/.



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Letters to the editor

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The cure is public

This summer, Canada's provincial and territorial premiers are gathering at the Council of the Federation. Prince Edward Island Premier Rob Lantz will host his counterparts from 21 to 23 July 2026 to discuss key national issues such as internal trade and labor mobility, health care, community safety, immigration, and economic development.

The premiers face a number of competing, parallel priorities—Quebec is preparing for a provincial election in October and Alberta is debating the merits of separation and has introduced two-tier health care with the passage of Bill 11.

It is important to ensure that the model created by Alberta's Bill 11 not take root or be allowed to spread to BC.

Bill 11 allows Alberta doctors to bill the publicly funded system for patient care while also charging patients privately for the same medically necessary services. It was passed in December 2025 and is expected to be implemented in phases in 2026.

Alberta's bill makes the provincial government the “payor of last resort”—the province will cover drug and supplemental benefits only if an individual does not have access to private insurance for the same or equivalent service.

By setting up a two-tier system where the wealthy have better access to care, Bill 11 directly contravenes the Canada Health Act. It throws the door wide open to private insurance companies and is an unprecedented attack on the principles of public medicare that keep the profit motive out of Canadian health care and ensure access is based on need, not the ability to pay.

As the premiers gather in Prince Edward Island to discuss cooperation on

trade, economic, health, and other issues, we need strong leadership from David Eby and the other premiers, sending a clear message that the provinces and territories expect the federal government to uphold and protect the Canada Health Act.

It is also important to let MLAs in BC know that two-tier health care is the wrong way to go.

Over the last year, British Columbians have seen construction for the new St. Paul's Hospital campus, a 204-bed replacement for the Cowichan District Hospital, and a new acute care tower at Royal Columbian Hospital. The BC government has delivered a new digital radiography X-ray machine and upgraded exam room at Port Hardy Hospital, provided free prescription contraception and diabetes medications, expanded the scope of practice for midwives, and opened the first new medical school in Western Canada in nearly 60 years, at Simon Fraser University in Surrey.

But we've also seen paused or canceled contracts for seven long-term care facility projects across the province, including Delta, Abbotsford, Chilliwack, Kelowna, and Fort St. John. We've seen scaling back of the BC Family Residence Program, which provides accommodation funding for families with seriously ill children traveling to Vancouver for medical care, hallway medicine and ER closures, and staff shortages in maternity and pediatric care in Kelowna and the Central Okanagan.

There is more to do to ensure all regions of the province and all families and individuals have access to care, hospitals, and a family doctor. Let's let government officials know we support continued efforts to strengthen and improve BC's health care

system. As for the gaps and ills that still remain—the cure is public.

—Cherie Payne, BA, LLB
Executive Director, BC Health Coalition

Re: Commemorating 2 centuries since the death of the inventor of the stethoscope

I really enjoyed the Beyond Medicine article about the inventor of the stethoscope [*BCMJ* 2026;68:93-95,109]. More like this, please, on the history of medicine!

—Helen Eng, MD
Surrey

Re: Appropriate use of diagnostic tests in medical practice

As a longtime teacher in our UBC Faculty of Medicine, I was pleased to see the article by Dr Wong—“Appropriate use of diagnostic tests in medical practice”—in the May 2026 issue of the *BCMJ*.¹ Dr Wong points out the value of the Choosing Wisely recommendations.^{1,2} It may be helpful to know that UBC medical students in their surgery clerkship block are advised to access the Choosing Wisely resources and are taught what I unashamedly call “Blair's four rules of testing.” They are:

- Do not order a test unless the results will truly change your management.
- Do not order a test unless you know what the result will mean for your patient.
- Consider the risk of the test and whether this risk is appropriate in the context of your patient's present and future health.
- If you are requesting a test, make sure you ask for it to be done correctly.

Students can learn to mimic physicists and their thought experiments: namely, to muse on how a patient's management may be affected if a test were to come back positive, negative, or inside or outside the normal range. For instance, if a requested C-reactive protein test comes back high or normal, should that truly change one's management, or has it been a waste of health care funds? Every test has a monetary cost, and a planetary cost, too.²

Along the same lines, if one asks for a test, one should have a good idea—before requesting it—of that test's reliability parameters, such as accuracy, specificity, and sensitivity, in that patient's context and the pretest probabilities.

No test is without risk. Some, such as angiograms and invasive biopsies, have known palpable risks, but there are risks of unintended consequences even with some apparently benign investigations. For example, a blood test done for no good reason that shows an abnormal result can sometimes lead the clinician and the patient into a Ulysses syndrome³ of needless further testing, anxiety, and real danger. I have witnessed tragic deaths in such needless pursuits and health insurance refusals based on one specious blood test with no evidence of disease.

Last, if testing is warranted, it should be done correctly. Some cautionary examples include serum cortisol testing done at an inappropriate time of day, CT scans done without appropriate contrast, flat-plate abdominal X-rays done when upright views are also needed, and so forth. If in doubt, ask. Testing should be regarded as a form of consultation, a gathering of evidence. Indeed, "ordering" a test is perhaps better said as "requesting" a test.

Dr Wong, in his excellent article, typifies these four rules with good examples from his field of infectious diseases. His message that a "test is useful only if the result can meaningfully influence decision making" is vital for our medical students to learn and carry into their future practices, no matter what field of medicine they pursue.

—**Geoffrey Blair, MD, FRSC**
Clinical Professor Emeritus, UBC

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Re: Everyone deserves better health care

The authors of "Everyone deserves better health care" clearly outline the problems with health care in Canada,¹ including a decline in hospital beds from 7 to 2.6 per 1000 people from 1970 to 2021.¹ Although not referenced in the article by Wang and colleagues, in 2025, there were 700 000 people in British Columbia without a family doctor.²

To put this in perspective, in February 2013, the Government of BC, along with the then-BC Medical Association, announced a \$132 million pilot program that would ensure that every resident had a family doctor.³ By April 2015, the Ministry of Health announced that it would not meet that goal and, having spent a lot of money, wrapped up the program but left the funding in place.⁴ By 2017, it was estimated that 700 000 people in BC did not have a family doctor.⁵ The situation hasn't improved, and those who cannot remember the past are condemned to repeat it.

Wang and colleagues embraced the standard Canadian solution to every problem: more money from the federal government. However, the federal government is not primarily responsible for funding health care. That is a provincial mandate.

There are no votes in addressing health care. Furthermore, there is simply no money. An editorial in *The Globe and Mail* posits that "Canada is a country drowning in a flood of red ink."⁶ The national debt is \$2.3 trillion.⁷ BC is running a \$13.3 billion deficit for 2026–2027, and the total provincial debt is \$183.4 billion.⁸ More recently, in April 2026, the Government of BC cancelled—or, to use its term, "re-paced"—the commitment to expand Burnaby Hospital.⁹

The federal government will *not* take a leadership role in health care. The federal

government is *not* going to invest in infrastructure for Fraser Health. There are more pressing needs for federal funding for defence, trade, and infrastructure.

We need bold leadership and outside-of-the-box thinking that totally rejigs the way we deliver health care in Canada today. Medicare in Canada, as we know, is a dysfunctional system. We need to embrace some of the innovation seen in European countries and provide affordable, quality health care with a mixture of private and public funding. Without new innovations, health care is going to get worse rather than better. I am pessimistic that this will not happen until the entire system collapses.

—**Derryck Smith, MD**
Vancouver

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Re: Gastroesophageal reflux disease and functional dyspepsia

I read with interest the excellent review articles on gastroesophageal reflux disease (GERD) and functional dyspepsia in the March 2026 issue of the *BCMj* [2026;68:62-68; 2026;68:69-75].

Considering the 4- to 8-week trials of proton-pump inhibitors frequently recommended and what are otherwise thoroughly comprehensive reviews, I note with concern the avoidance in both articles of even mentioning rebound acid hypersecretion as a side effect of proton-pump inhibitors.

This is a well-documented ubiquitous phenomenon, shown to exist in the 1980s (including with proof-of-concept physiological studies). It was proven clinically by placebo-controlled studies over 15 years ago (over 40% of previously asymptomatic volunteers suffered GERD symptoms following discontinuation of proton-pump inhibitors after 8 weeks of use). Worryingly, recent review articles cite multiple methodologically challenged studies and the need for better studies to risk stratify at patient populations, better identify clinically relevant outcomes, and develop efficacious withdrawal protocols.

While some of the indications for proton-pump inhibitors require long-term treatment, others do not.

A 4- to 8-week trial of therapy has a high likelihood of resulting in rebound acid hypersecretion.

Symptom relief after commencing proton-pump inhibitors occurs within a few days in most uncomplicated GERD patients (although mucosal healing will take longer).

In uncomplicated GERD patients, would it not be wiser to do a much shorter trial (less than 2 weeks) and assess symptomatic response within that time?

Considering the number of patients on long-term proton-pump inhibitor therapy and the unanswered rebound acid hypersecretion question, I hope for robust debate of the topic and look forward to a future article.

—Roger Seldon, MBChB, MD, CCFP
Campbell River

Additional reading

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Authors reply

We thank Dr Seldon for his thoughtful letter and for raising the possibility of rebound acid hypersecretion (RAHS) following proton-pump inhibitor (PPI) withdrawal. We agree that judicious prescribing and deprescribing of PPIs deserve emphasis in primary care, and we welcome the opportunity to clarify our recommendations.

The randomized control trial¹ cited by Dr Seldon reported acid-related symptoms in approximately 44% of healthy volunteers after 8 weeks of PPI therapy, raising concern for RAHS. There are limited studies that support similar outcomes, with many methodological weaknesses limiting the clinical relevance of the findings. We note that Niklasson and colleagues² is the only study to produce similar results, with 44% of the PPI group in healthy volunteers developing

dyspepsia after withdrawal. However, subsequent studies have shown contrasting findings, as noted below.

First, Reimer and colleagues¹ treated patients for 8 weeks, which is the upper end of the recommended 4- to 8-week trial of PPI therapy; thus, in patients in whom PPI is appropriately trialed and deprescribed, RAHS is of lower clinical concern. Moreover, while Niklasson and colleagues saw similar rates of symptoms after PPI withdrawal, these symptoms resolved by the third week after discontinuation, much sooner than reported by Reimer and colleagues.¹ Therefore, in patients who may experience RAHS, this is not a chronic symptom. Moreover, Reimer and colleagues used not objective measurements but rather symptom questionnaires; accordingly, the correlation between symptoms and rebound acid secretion was inferred, rather than demonstrated. Finally, both studies used healthy volunteers, limiting our ability to extrapolate the findings to patients with GERD, where symptom recurrence after PPI withdrawal may be the natural history of their underlying GERD rather than a rebound acid secretion phenomenon.

Several studies cite contrasting evidence, supporting safe prescribing and deprescribing of PPI therapy. An RCT by Boyce and colleagues³ treated healthy volunteers with PPI for 4 weeks and found that gastrin and chromogranin A levels returned to baseline within 2 or 3 days of PPI withdrawal, with no reported rebound dyspepsia. A systematic review by Lødrup and colleagues⁴ found only two studies that supported RAHS—Reimer and colleagues¹ and Niklasson and colleagues,² as discussed above. The authors also noted that given the lack of objective measurements, RAHS was inferred; therefore, the clinical significance of the mild to modest self-reported symptoms is unclear. Notably, Lødrup and colleagues also found that while RAHS induced symptoms in healthy volunteers, studies in patients with pre-existing reflux disease did not demonstrate any additional symptom burden attributable to RAHS.⁴ Both the American College of

Gastroenterology (ACG) and the American Gastroenterological Association (AGA), in their respective guidelines,^{5,6} recognize RAHS as a physiologic phenomenon but note that strong evidence for the clinical significance of this is currently lacking. Moreover, there are no studies that have used true pH-impedance monitoring to demonstrate true reflux: Niklasson and colleagues measured gastrin and chromogranin A levels; thus, their demonstrated correlation is indirect.² Therefore, given the present body of evidence, there is no direct correlation between postwithdrawal symptoms and true acid hypersecretion, and symptoms may represent esophageal hypersensitivity, functional heartburn, or recurrent GERD.

Guidelines from the ACG and AGA⁵⁻⁷ recommend a duration of 4 to 8 weeks as an adequate trial of PPI therapy. Regarding the use of shorter durations in uncomplicated GERD, while symptomatic relief often begins within days, mucosal healing in patients with unrecognized erosive esophagitis or reflux-related gastritis requires an appropriate treatment duration of 4 to 8 weeks. This also allows for assessment of durable clinical response. Truncating therapy at less than 2 weeks risks undertreatment of erosive disease and a falsely negative therapeutic trial, prompting unnecessary investigation or premature escalation to invasive testing such as endoscopy.

While we continue to recommend a trial of 4 to 8 weeks of therapy, we do endorse Dr Seldon's broader point: PPIs are commonly overprescribed and underdeprescribed. For patients continued on PPI therapy beyond 8 weeks, if clinically appropriate, a gradual taper and step-down to the lowest effective dose—including on-demand or intermittent use in non-erosive reflux disease—should be considered to mitigate the potential risk of rebound symptoms. As per the AGA's GERD management guidelines,⁸ in patients with objectively unproven GERD who have required PPI use for 12 months, we recommend esophageal reflux testing to clarify the indication

for prolonged PPI use. This is consistent with all the recommendations in our article. The 2022 *AGA Clinical Practice Update on De-Prescribing of Proton Pump Inhibitors*⁷ provides a practical framework that we would recommend to readers interested in this area.

We thank Dr Seldon for prompting this discussion and agree that further high-quality data on RAHS risk stratification and withdrawal protocols would benefit the field.

—Estello Nap Hill, MD

—Gunisha Kalra, MD

—Sarvee Moosavi, MD, FRCPC, EdM, AGAF

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Correction

Postpublication, the authors of "Functional dyspepsia: Diagnosis and management in a primary care setting" [*BCMj* 2026;68:69-75] requested a change to their placement of the bulleted lists of symptoms in each circle in the Venn diagram in **Figure 2**. In June 2026, the symptoms in the two circles were corrected in the online version of the article at bcmj.org. The black and white arrows in the figure below illustrate how the symptoms should appear.

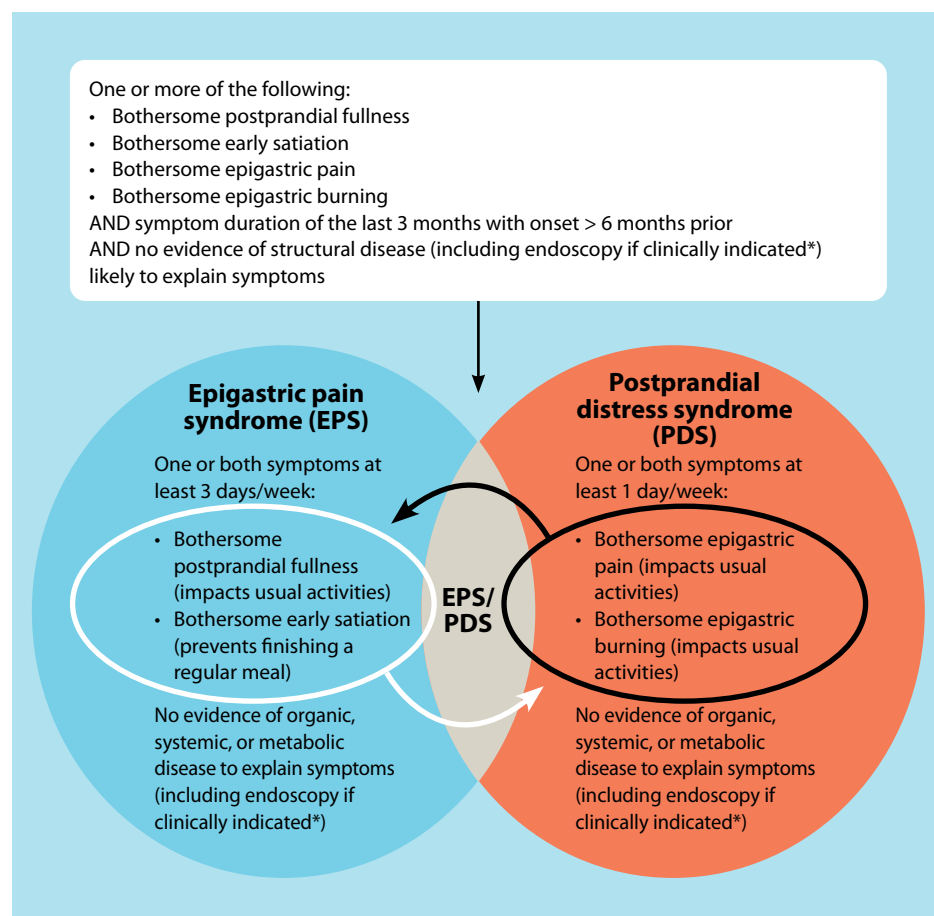


FIGURE 2. Rome IV criteria for functional dyspepsia. Adapted from the Rome IV criteria for functional dyspepsia, with supportive features for postprandial distress syndrome (PDS)/epigastric pain syndrome (EPS) excluded²¹ and endoscopic investigation recommended only if clinically indicated as per the American College of Gastroenterology (ACG) and Canadian Association of Gastroenterology (CAG) guidelines.²³

* As per the ACG/CAG guidelines, endoscopy is indicated in symptomatic patients 60 years of age or older; the decision for endoscopy should be individualized in patients 55 years of age or older of Southeast Asian descent and in patients of any age in whom an alarm feature is prominent.²³



Championing the profession: Doctors of BC's long-standing Health Professions and Occupations Act advocacy

On 1 April 2026, the new Health Professions and Occupations Act (HPOA) took full effect, introducing significant changes to the regulation of health professions in BC. I was at the Doctors of BC Board meeting in 2019 when we became aware that changes were on the horizon, following the release of the Cayton Report—an inquiry into the performance of the College of Dental Surgeons of British Columbia, along with recommendations on broader health profession regulation modernization.¹ Since that moment, Doctors of BC has advocated extensively on behalf of physicians, raising concerns with government about the HPOA's potential unintended consequences for the profession and patient care. We have also consistently emphasized the importance of meaningful consultation and engagement with physicians and other health care professionals. Unfortunately, it appears that the government has not listened to many of our concerns.

While there is support for some aspects of the HPOA, other changes remain deeply concerning to many of us. These include expanded government oversight of professional regulation, heightened anxiety and fear of retaliation stemming from the new complaints and investigations process, and a growing shift toward a culture of defensive medicine that could further increase health care costs. Many physicians are also reporting increasing moral injury and concerns about psychological safety.

Members have made it clear that BC needs a balanced approach to regulating health professionals that recognizes and

supports professional expertise, autonomy, and accountability. At a time when our province faces a serious health human resource crisis, physicians need assurance that their work is valued and that they remain trusted partners in the health care system. Overly rigid regulation signals mistrust and undermines the conditions needed for a high-functioning, sustainable health care system.

At a time when our province faces a serious health human resource crisis, physicians need assurance that their work is valued and that they remain trusted partners in the health care system.

Now that the HPOA is in effect, Doctors of BC is shifting its advocacy focus to monitoring the legislation's impact on physicians and advocating for mechanisms that ensure health professionals have meaningful influence over HPOA-related matters.

A key part of this work is hearing directly from members about their experiences. Already, some physicians have told us that the HPOA is contributing to early retirement decisions, while others are considering leaving the province. We want to better understand how these changes are affecting you and your practice. I encourage you to share your experiences through our "Have Your Say" online engagement platform

(<https://haveyoursaydoctorsofbc.ca>). Your feedback will help inform and strengthen our ongoing advocacy efforts.

Doctors of BC will provide ongoing updates and resources to help members navigate practice under the HPOA. Additional information on our advocacy efforts, member engagement, and ongoing work related to the legislation is available on the dedicated HPOA web page (www.doctorsofbc.ca/HPOA).

When it comes to advocating on your behalf—whether about the HPOA or about any issue affecting physicians and patient care—I encourage you to keep speaking up and working with us. Together, our voices are stronger. ■

—Adam Thompson, MD
Doctors of BC President

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Primary care is the focus of Simon Fraser University's new School of Medicine

As Simon Fraser University opens its doors to its first class of medical students, the *BCMJ* spoke with Dr David Price, dean of medicine.

Tara Lyon



Dr David Price, dean of the SFU School of Medicine.

In August 2026, the first new school of medicine in Western Canada since 1950 is welcoming its first students. The Simon Fraser University (SFU) School of Medicine, with a curriculum centred on family medicine and primary care specialties, aims to improve access to primary care in BC by training physicians to work in urban, rural, remote, and Indigenous communities.

The university's founding dean of medicine, Dr David Price, set out to create a medical school that flips the script on traditional physician training. Unique health care challenges require unique solutions, and with 35 years' experience in community-based primary care specialties, Dr Price was well qualified to design a new kind of medical school. He explains: "What really interested me was thinking about primary care in a larger sense—was this going to be a family medicine-specific school, or would it be broader than that? So, to think about family medicine for sure, but to consider the other primary care specialties, like pediatrics, psychiatry, public health, emergency medicine, OB/GYN, and other community-based specialties, that's what brought me on board. And, who gets the opportunity to help design a medical school

from the ground up? It's the opportunity of a lifetime."

Initially invited to act as interim dean to help design the school, Dr Price went on to accept the permanent dean position. When he came on board, he first set out to consider community needs and find ways to focus the school's curriculum and recruitment with a uniquely primary care lens.

"We're starting with family medicine residencies, but our commitment is to increase to a number of other primary care residency specialties, like pediatrics, psychiatry, and general internal medicine."

Taking a fresh approach to designing a medical school curriculum presented some interesting challenges. "Any time you start a new endeavor like this, trying not to go down a well-trodden path and instead forge your own path, that engenders challenges," says Dr Price. "If we'd tried to do it just like UBC or McMaster, or [the Uni-

versity of] Calgary, or McGill, then why create a new school? We can just do it exactly the same way it's always been done. But if we do that, we're going to get the same results that other medical schools across the country get: only 25% of students graduating from other Canadian medical schools choose family medicine, and only 30% to 35% choose any kind of primary care specialty. I'm a proud UBC grad; I was at McMaster and McGill, too. I've done accreditations and external reviews at about

Ms Lyon is production editor of the BC Medical Journal.

70% of the medical schools in Canada, and those schools produce amazing graduates. But if we want to improve the number of students who choose primary care and other community-based specialties, we're going to have to approach things differently."

One of the earliest decisions Dr Price and his colleagues made was to flip the medical school's learning curriculum from a hospital to a community focus. "In most medical schools, students spend 70% to 80% of their time learning, either in the university or in the hospital, and then spend 20% to 30% out in the community. We're flipping that. We're saying we want to do 70% or so in the community and 20% to 30% in the hospital. And that creates its own challenge: helping the hospitals and health authorities understand that the training that happens in hospitals isn't less valuable; it's essential. But we need to ensure that the training our students receive is relevant for the profession we hope they go into, the profession they choose during the CaRMS Residency Match."

Once Dr Price and his team landed on the school's innovative curriculum ratio switch, it was time to get the government on board. "The challenge at that point was to convince the government that this all makes

sense," he explains. "The government wants us to produce more family physicians, but I'm not sure they'd really thought beyond that in terms of how to get there. And as we started to articulate our vision for a primary care-focused medical school (and yes, that took a bit of convincing), it's evolved into a very supportive relationship with the bureaucrats and the various ministries."

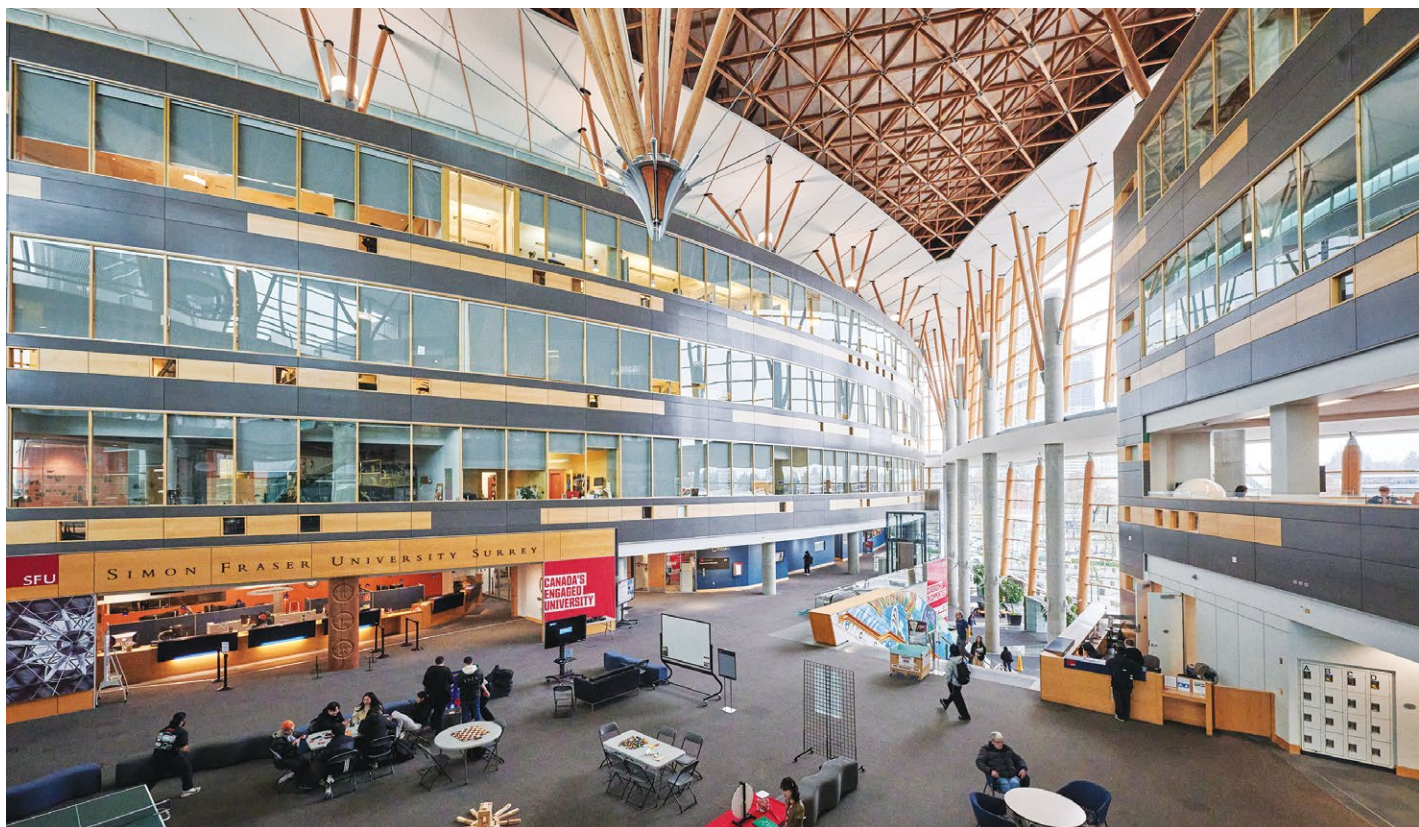
Dr Price identifies the partnerships developed in the school's planning process as a win. "I'm proud not only of the team we've been able to recruit—from here in BC, and also from across the country and internationally—but also of the relationships we've built," he explains. "The First Nations Health Authority has been incredibly supportive in helping us understand how to add Indigenous ways of knowing and being—and, more importantly, an Indigenous concept of wellness—to our curriculum, as well as how we approach faculty and staff and the culture in the school. Our partnerships with Fraser Health and the Divisions of Family Practice are also key. All our partners have asked really good questions; they've pushed us to think broadly, and they've been extraordinarily supportive, so all of that has played into how I think our school will evolve and grow."

Recruiting faculty hinged on posting positions and getting the word out quickly. Once positions were posted, says Dr Price, there was a period of leveraging connections to encourage candidates to apply and convince them that it would be worth it to relocate and support the new school. "For many of our new faculty members, it was a bit of a leap of faith, but any dean can tell you that a big part of their job is to go out and recruit faculty and convince them that working for their own particular medical school is a really worthwhile endeavor." While many faculty members are family physicians, other specialties are represented as well. "We have a number of clinical faculty who practise in specialties other than family medicine. One of our senior advisors from Fraser Health is an ophthalmologist, our associate dean of learners is a respirologist, but we're a primary care school, so our faculty really is more focused in the primary care disciplines."

Dr Price says that the SFU medical school will work with UBC's medical school to find efficiencies by sharing resources whenever possible. "Our commitment to UBC, government, and BC taxpayers is that where there are opportunities to collaborate, we will. For example, we're sharing



Dr David Price (centre), dean of the SFU School of Medicine, connects with two members of the Learner Affairs team.



The SFU Surrey campus mezzanine. The first class of medical students will begin their studies at the SFU Surrey campus (an interim location). The permanent School of Medicine will be built next to the SFU Surrey campus and Surrey Central Station.

call rooms in the hospitals, teaching centres, and so on. As well, the UBC faculty [have] been generous with their time, collaboration, and conversations to help us ensure we're not reinventing the wheel. With that being said, there's an hour between our campus and UBC, so it's pretty tough to duplicate the use of some in situ learning materials, because it's just too far. But when it comes to hospital settings, where there's taxpayer-funded infrastructure, we're going to be respectful in our use and sharing of that."

The school has two selection streams for students: an open stream, available to all students from British Columbia and the territories, and an Indigenous stream, open to Indigenous students from across Canada. When it comes to students' grade point average (GPA) and academic qualifications, the school will be taking a fresh approach. "With GPA, the evidence is that you need to have been generally successful in a rigorous academic program to then succeed

in a program such as medicine. We know, based on evidence, the minimum [Medical College Admission Test] score you need to have to be successful in medical school. So if you clear that bar, we will no longer look at your marks—we'll start to look at your other attributes. As a primary care medical school, we're going to look at community engagement and connection activities that would demonstrate to us that you're excited about a career in a primary care discipline." Dr Price hopes that taking this approach to admissions will ease stress for students who have been solely focused on maintaining near-perfect grades. "We know that life happens," he says. "Folks get sick, and you can't always do as well. You get injured playing sports. A family member gets sick. You need to hold down a part-time job to help put yourself through school. There are all kinds of reasons why extraordinarily bright, capable, talented individuals can't get that 3.9999 GPA but still do remarkably well, and those are the students that we hope will

be able to demonstrate that they should be a part of our program."

The school's family medicine residency program will start on 1 July 2027, with a commitment to having the same proportion of residency spots as UBC and other medical schools across the country. "We're starting with family medicine residencies, but our commitment is to increase to a number of other primary care residency specialties, like pediatrics, psychiatry, and general internal medicine," says Dr Price.

There are still opportunities for BC physicians to get involved with the SFU medical school. "There are other focused teaching roles that will become available," says Dr Price. "We have a great mix of clinical faculty so far, and we'd love to hear from you if you'd like to contribute."

For a list of available positions at the SFU School of Medicine, visit www.sfu.ca/medicine/contact/careers.html. ■

A call for policy change: Funding fertility treatments for medical trainees

Medical trainees experience disproportionately high rates of infertility, driven in part by training-related delays in childbearing, and face significant financial and institutional barriers to accessing fertility care, highlighting the need for equitable, standardized policies and insurance coverage for fertility preservation and treatment across Canada.

Kaitlyn Mazza, MD, Niamh Tallon, MB, BCh, BAO, FRCSC

Medical trainees make countless sacrifices in pursuit of their careers: weekends, holidays, sleep, and often their own well-being. Are they also sacrificing their ability to achieve their long-term family goals? For women in particular, the answer is often yes. Fertility is strongly age dependent, with a well-recognized steep decline after age 35.¹ Between 2020 and 2024, the average age of female medical school graduates in Canada was 27.3 years.² These years of training coincide with their peak reproductive years.

The impact of infertility, however, is not isolated to women. In 2023, the American Society for Reproductive Medicine expanded its definition of infertility to include not only medical inability to conceive but also social infertility. Social infertility includes individuals in same-sex relationships, single parents by choice, and individuals who have undergone gender-affirming medical or surgical care.³ This broader definition more

accurately reflects the growing diversity of individuals seeking assistance with family building.

Fertility care extends beyond treatment of infertility and must be reflected in equitable coverage policies, including elective oocyte cryopreservation. This approach allows trainees to preserve reproductive potential during training and supports a preventive model of care. Elective oocyte cryopreservation mitigates age-related decline in oocyte quality, with the goal of reducing the need for more invasive and costly interventions in the future.

Infertility among physicians is consistently reported at more than double the rate of the general population (24% to 33% versus 12%).⁴ Female surgical trainees are especially affected, with one study showing that 84% of female surgeons underwent infertility evaluation and 76% ultimately required assisted reproductive technology to conceive.⁵ Physicians—residents in particular—are also at higher risk for adverse pregnancy outcomes, including elevated rates of preterm delivery, preeclampsia, intrauterine growth restriction, and stillbirth.^{6,7} Miller and colleagues have even suggested that residents should be considered a high-risk obstetric population.⁶

The University of Calgary's Department of Obstetrics and Gynecology recently surveyed surgical trainees across Alberta. Nearly 85% were childless, yet 82% desired two or more children in the future.⁸ Consistent

with Canadian and international data, the majority planned to delay childbearing well into their 30s due to career demands, financial barriers, and limited institutional support.⁸ Strikingly, many trainees underestimated the impact of age-related fertility decline while overestimating the success rates of assisted reproductive technology.⁸ In fact, studies estimate that a couple desiring two children should begin attempting to conceive when the female partner is age 27 at the oldest for a 90% chance of success without intervention.⁹ Despite this, the average age of first-time mothers in Canada was 31.7 years in 2023.¹⁰

Among trainees who sought fertility support during training, access was often limited by a lack of policies and program standards. In British Columbia, the current resident contract includes no specific provisions for fertility-related care, in contrast to the clearer leave structures for prenatal care.^{11,12} This disparity leaves trainees who require fertility supports at an even greater disadvantage to meeting their family goals than their peers who conceive without assistance.

Medical trainees dedicate their time and energy to caring for patients, and they deserve comparable support in achieving their family-building goals. Trainees earn incomes that are comparable to, or only modestly above, the median individual income in Canada and British Columbia, with most carrying substantial educational

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This article has been peer reviewed.

debt.¹³ In Canada, a single cycle of in vitro fertilization (IVF) costs approximately \$18 000 to \$25 000, including medications and embryo transfer.¹⁴ Oocyte cryopreservation is similarly expensive, at approximately \$15 000 to \$20 000 per cycle.¹⁴ This leaves fertility treatment largely inaccessible to trainees without insurance coverage.

Beyond financial considerations, access to fertility care is logistically challenging for trainees. Treatment requires frequent appointments for cycle monitoring, egg retrievals, and embryo transfers, as well as recovery time, necessitating time away from clinical duties. In the absence of standardized policies and program support, trainees may face major scheduling difficulties, limiting access to care.

Nearly 83% of surgical trainees in Alberta reported that they would consider oocyte cryopreservation or infertility treatment if insurance coverage were available.⁸ Other studies echo this finding, with almost 40% of medical students indicating that fertility benefits would influence their choice of residency program.^{8,15–17} Given the substantial physician shortage in British Columbia, the inclusion of fertility benefits represents a meaningful incentive to attract and retain trainees.¹⁸

This issue is not isolated to BC. Across Canada, fertility coverage remains inconsistent, with most medical trainee programs offering little or no fertility support. Ontario and Nova Scotia provide some trainee-specific benefits: members of the Professional Association of Residents of Ontario receive full coverage for fertility medications, while Maritime Resident Doctors members are eligible for up to \$15 000 in fertility drug coverage.^{19–25} These models establish a precedent for expanding trainee-specific fertility benefits across Canada and support a broader adoption of similar benefits.

At the provincial level, funding models also vary widely. Ontario and Quebec both fund one cycle of IVF and unlimited coverage for intrauterine insemination. Other provinces offer partial funding or reimbursement models: Manitoba and

Nova Scotia fund approximately 40% of treatment costs, with a defined annual and lifetime maximum, while Saskatchewan funds 50% of coverage up to a lifetime maximum. Prince Edward Island offers income-based reimbursement up to \$10 000 annually, and Newfoundland and Labrador provides up to \$20 000 in lifetime funding. New Brunswick offers a one-time grant of up to \$20 000 for IVF or \$10 000 for intrauterine insemination, while Yukon provides a tax credit covering 40% of treatment costs up to \$10 000 annually. In contrast, Alberta, Nunavut, and the Northwest Territories currently provide no public funding.²⁶

**Infertility among
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double the rate of the
general population
(24% to 33% versus 12%).**

The recent introduction of a publicly funded IVF program in British Columbia, which covers one funded cycle for eligible applicants, emphasizes the growing recognition of fertility care as a public health priority. However, this program is currently structured as a temporary initiative and includes eligibility criteria such as age (18–41 years) and household income below \$250 000.²⁷ While most trainees meet these eligibility criteria, access remains limited due to the timing and structure of treatment during medical training. Coverage is also restricted to individuals actively attempting conception, excluding fertility preservation strategies.²⁷ Further, demand for such services far exceeds the current budget provisions, and without supplemental insurance coverage, fertility treatment remains unattainable for most trainees.

Pacific Blue Cross, the insurance provider for BC medical trainees, has promoted its commitment to family planning, partnering with the BC Women's Health Foundation

to launch a new plan that expanded family planning benefits.²⁸ Yet, this is not the plan offered to residents. The current Resident Doctors of BC contract explicitly excludes fertility drugs and treatments, aside from a \$500 annual health savings account.¹¹

Over the past 3 decades, female representation in medicine has increased by 27%, with women now comprising more than half of medical graduates.² Canada is also home to 1.3 million individuals who identify as part of the 2SLGBTQ+ community (4.4% of the population), more than 40% of whom desire children.²⁹ Without fertility coverage, many of these individuals sacrifice their reproductive goals to pursue medical training. The consequences extend beyond personal hardship—ultimately influencing specialty choice, exacerbating physician shortages, and increasing the burden of high-risk pregnancies on the health care system.

Fertility preservation and treatment must be recognized as essential components of reproductive health, alongside prenatal care and parental leave. Provincial and national standards are urgently needed to ensure equitable, transparent, and consistent access for trainees. By addressing these barriers through education, counseling, and insurance coverage, we can support the health and wellness of future physicians. In doing so, we allow trainees to pursue both their professional and personal aspirations, ultimately strengthening the medical workforce and the communities it serves. ■

Competing interests

Dr Mazza has no competing interests to declare. Dr Tallon is the medical director of Olive Fertility Centre Victoria and co-director of Olive Fertility Centre Vancouver.

Artificial intelligence

The authors used an artificial intelligence–based language tool to assist with reference formatting. All content was reviewed and verified by the authors.

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Beyond the cloudy lens: A physician's guide to cataract treatment

Cataracts are one of the most common causes of vision loss, but cataract surgery is extremely safe and is one of the most cost-effective treatments in medicine.

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ABSTRACT: Cataracts are the progressive opacification of the crystalline lens. In British Columbia, cataracts are the leading cause of low vision, and their prevalence increases as the population ages. While most cataracts are age related, additional risk factors include

genetic predisposition; smoking; UVB exposure; corticosteroid use; diabetes; trauma; and prior ocular surgery, disease, or injury. Patients commonly present with progressive blurred vision, glare, and monocular diplopia. Diagnosis is typically made with slit-lamp examination, although reduced visual acuity and a diminished red reflex on ophthalmoscopy may raise suspicion. Cataract surgery is the only definitive treatment and is recommended when visual impairment significantly affects quality of life or interferes with ocular health management. Modern surgery involves phacoemulsification with intraocular lens implantation. It has excellent safety and efficacy profiles and is a cost-effective mechanism for restoring vision.

smoking, UVB or other radiation exposure, prolonged corticosteroid use, uncontrolled diabetes, other systemic or ocular diseases, prior ocular surgery or trauma, and chemical or electrical injury.^{3,4}

A cataract can be classified according to three types based on the location of the opacification: nuclear, cortical, or posterior subcapsular.⁴ In most patients, more than one type exist simultaneously; however, the workup and treatment for any cataract type is the same.^{3,4} While patient complaints may vary depending on the type and severity of the cataract, common complaints include worsening blurry vision, glare and halos from lights (especially when driving at night), colors becoming less vibrant, and monocular diplopia.¹⁻⁴

Clinical assessment

Apart from occupational requirements (e.g., aircraft pilot, law enforcement) and/or legal requirements (e.g., driver's licence renewal), there is no evidence to support the screening of cataracts in patients without visual complaints.^{5,6} However, some patients may fail to notice their cataract progression or to verbalize a significant visual decline.^{5,6} Thus, it is important for health care providers to recognize the risk factors and consider cataracts as a cause of functional decline. Visual impairment increases the risk of depression, withdrawal from social activities, avoidance of driving, and increased falls.^{7,8} Patients may suddenly become aware of their cataract progression and present with a complaint of acute and rapid vision decline despite a subacute to chronic process.

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The gold standard for assessing cataracts is with a slit lamp, but examination with an ophthalmoscope, combined with a Snellen visual acuity chart, can have a high positive predictive value.^{5,6} A patient with cataracts may have a dull or absent red reflex and reduced visual acuity in the affected eye(s). When making the decision to refer a patient to an ophthalmologist for cataract assessment, one should specify the suspected eye(s), the functional impact of potential visual decline on the patient, and the patient's interest in pursuing surgical treatment. While the only definitive treatment for cataracts is surgery, some patients may benefit from optimizing their refractive prescription, using tinted lenses or magnifying glasses as short-term solutions.³⁻⁶

Indications for cataract surgery

Once the patient is referred to an ophthalmologist for assessment, the decision to recommend surgery is made in a patient-centred process. The best corrected Snellen visual acuity is an important objective measurement, but subjective difficulties performing everyday activities such as driving, watching TV, or reading remain the deciding factor for most patients.⁹ The presence of a cataract is not an indication for surgery, but having visually significant and quality-of-life-impairment is.¹⁰ Another indication for cataract surgery in elderly patients is to improve cognitive function and slow dementia progression.^{7,8,10} Finally, cataract surgery may be recommended if the lens itself is threatening ocular health or care.¹⁰ Examples of such include secondary cataract-related glaucomatous disease (e.g., pupil block, acute angle closure) or impairment of visualization of the retina for the management of posterior segment disease (e.g., diabetic retinopathy, ocular tumors, age-related macular degeneration). It may also be recommended if driving criteria are not met.

In a presbyopic (age-related loss of ability to focus at near distances) patient who does not have visually significant cataracts or any of the above indications, an elective surgery known as “clear lens exchange” may

be performed, although it is not covered by the BC Medical Services Plan (MSP).¹¹ This is identical to traditional cataract surgery, but its main goal is to reduce spectacle dependence in individuals who have not yet developed a cloudy lens but wish to improve their vision.¹¹ A patient who has undergone clear lens exchange in an eye will not develop a cataract in that eye in the future. Clear lens exchange, or cataract surgery, is distinct from laser refractive surgeries (LASIK or PRK), which alter the shape of the cornea without affecting the native lens.

Preoperative considerations

Surgical planning also requires physicians to screen for any health conditions that may compromise a safe operation. Common concerns include respiratory conditions that affect the patient's ability to lie comfortably in the supine surgical position and psychiatric conditions that affect the patient's ability to remain as stationary as possible.^{12,13} While almost all cataract surgeries are performed with topical anesthesia with or without oral/intravenous sedation, a severely anxious patient or a patient suffering from dementia may require a retrobulbar block to achieve total orbital anesthesia and paresis.¹³ General anesthesia may be indicated in most pediatric patients but very rarely in adults.¹³

In BC, almost all cataract surgeries are done unilaterally. However, when general anesthesia is required, patients may be considered for immediately sequential bilateral cataract surgery. This requires two sets of separately sterilized equipment, repositioning, and redraping the patient to minimize the risk of contaminated equipment affecting the eyes. With the exception of rare cases, immediately sequential bilateral cataract surgery is not the practice pattern in BC, although newer data suggest this approach may have benefits compared with unilateral surgery.¹⁴

Cataract surgery

Cataract surgery is typically performed in hospital operating rooms, day surgery units, or outpatient surgical centres. A

typical surgery takes less than 20 minutes to perform. After dilation of the pupil in the preoperative area, the surgeon makes a small incision in the cornea and opens the capsule (“skin”) of the cataract, allowing an ultrasonic probe to access the cataract and fragment/aspirate it. After removal of the cataract lens, the artificial intraocular lens, usually made of acrylic, is placed in the capsular bag. Following surgery, patients are instructed to use antibiotic and anti-inflammatory eye drops for a number of weeks. Typically, patients are followed up at 1 day, 1 to 2 weeks, and 4 to 6 weeks postoperatively, although follow-up intervals may vary between practitioners.

Intraocular lens options and refractive planning

Providing preoperative education when choosing artificial intraocular lenses and managing patient expectations according to their refractive goals play a large role in postoperative patient satisfaction.^{15,16} A variety of artificial intraocular lenses are available for cataract surgery.¹⁵⁻¹⁷ They may provide improved vision at a single point (monofocal) or for a range of vision (multifocal). Additionally, correction of astigmatism (imperfection in the curvature of the eye) can be achieved with toric artificial intraocular lenses, both monofocal and multifocal.¹⁷

MSP will pay for numerous monofocal artificial intraocular lenses. Patients who opt for monofocal artificial intraocular lenses generally choose to have a refractive goal of bilateral emmetropia, bilateral myopia, or monovision.¹⁵⁻¹⁷ With bilateral emmetropia, the working distance is set to distance vision, and patients will have good distance vision but will rely on reading glasses for near vision.¹⁵⁻¹⁷ A bilateral myopic target will leave the patient mildly nearsighted.¹⁵⁻¹⁷ This will necessitate the use of glasses for distance vision but will maintain intact near vision.¹⁵⁻¹⁷ Monovision is a combination of having one emmetropic eye and one myopic eye.¹⁸ This strategy may provide increased spectacle independence at the cost of depth perception.¹⁸

In patients with a strong desire for spectacle independence, alternative artificial intraocular lenses may be suitable options; they include multifocal artificial intraocular lenses [Figure], accommodative artificial intraocular lenses, and extended depth-of-focus artificial intraocular lenses.¹⁹ These alternative artificial intraocular lenses are not covered by MSP; they are paid for by the patient to the hospital or health authority where the patient will have their surgery. Prices vary from less than \$100 to more than \$1600 per artificial intraocular lens, depending on the type selected. To optimize outcomes for these patients, surgeons typically require additional pre-operative diagnostic testing, which is not covered by MSP. The main drawbacks of these lenses are increased risk of glare and halos and decreased light sensitivity (i.e., reduced contrast).¹⁹ Patients who select these artificial intraocular lenses must be aware of potential challenges in low-light situations, such as night driving.¹⁹ Finally, toric versions of each aforementioned artificial intraocular lens exist and can correct corneal astigmatism to further reduce spectacle dependence.^{15-17,19} Toric artificial intraocular lenses necessitate placement in a specific axis; in less than 1% of cases, excessive rotational instability may necessitate a secondary repositioning surgery.²⁰

It is important to realize that the goal of cataract surgery is not complete spectacle independence. Rather, realistic expectations include a reduction in spectacle dependence, as well as visual improvement in tasks that had been prioritized before surgery. Last, artificial intraocular lens selection is a highly individualized process that considers patient lifestyle, patient desire for spectacle independence and tolerance for dysphotopsias, pre-existing eye conditions, and surgeon factors.

Outcomes of cataract surgery

Based on metrics such as quality-adjusted life-years and increased economic productivity, cataract surgery is one of the most cost-effective treatments in medicine.²¹⁻²³ More than 95% of patients obtain

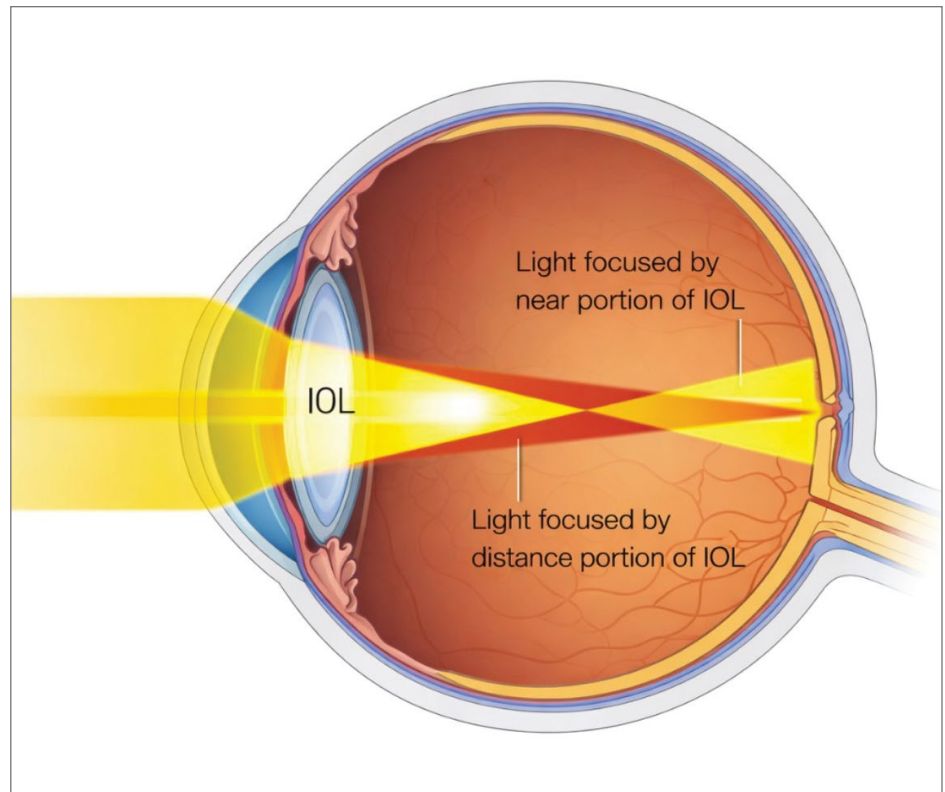


FIGURE. Simplified optics of a multifocal (bifocal) intraocular lens (IOL). Note that light is focused at multiple points, allowing clear vision at multiple distances. This also results in unfocused light rays reaching the retina, which contributes to glare and halos. Decreased contrast sensitivity also results as a “splitting” of the finite amount of light entering through the pupil.

a satisfactory visual outcome in both the short term and long term.^{22,23} Other benefits include a reduction in all-cause mortality, a reduction in falls leading to fractures, and a reduced fear of falling; increased independence in performing (instrumental) activities of daily living; and improved social connection, mental well-being, and cognitive function.^{7,8,22,23} The most common risks of cataract surgery are dry eyes and posterior capsular opacification.^{5,6,12}

Most postcataract patients develop posterior capsular opacifications and complain of a decline in vision.^{6,12} This can easily be treated with a one-time, MSP-covered office laser procedure called YAG laser capsulotomy.^{6,12} Another common postoperative complaint is dysphotopsia, which can present as positive or negative types.^{12,23} Positive dysphotopsias present as light streaks, glare, starbursts, or light rings and occur in up to 67% of patients; negative dysphotopsias are described as a crescentic

or linear shadow and occur in up to 27% of patients.^{12,23} The etiology of dysphotopsias is attributed to patients adapting to “seeing” the edge of the intraocular lens, and almost all patients report spontaneous resolution of symptoms within the first year.^{12,23} Another potential complication after cataract surgery is cystoid macular edema, a retinal swelling occurring in approximately 1% to 2% of patients.¹² The prognosis for postoperative cystoid macular edema is also good, with no further surgical interventions required to achieve a satisfactory visual outcome.¹²

Serious adverse events due to cataract surgery are rare but include endophthalmitis (infection), vitreous hemorrhage, retinal detachment, intraocular pressure spikes, and toxic anterior segment syndrome (severe noninfectious inflammation).¹² The cumulative incidence of sight-threatening complications postcataract surgery is less than 1%.¹² They are most likely to occur in the 2-week postoperative period, and

patients should follow up with their surgeon immediately if they develop reduced vision, a worsening red eye, worsening eye pain, development of numerous floaters, and/or periorbital swelling.¹²

New technologies

Many innovative technologies have emerged in the world of cataract surgery. One of the most recent developments is femtosecond laser-assisted cataract surgery (FLACS).²⁴ In FLACS, a computer-guided laser performs multiple key steps that are usually performed manually by the surgeon.²⁴ While FLACS results in improved precision of each step compared with traditional manual techniques, there is no evidence that it has an improved safety profile or improved patient outcomes in the general population compared with standard cataract surgery.^{24,25} The benefit of FLACS compared with traditional cataract surgery is supported by studies that have demonstrated that it can more predictably manage postoperative astigmatism and may improve outcomes in patients with select ocular comorbidities.^{24,25} FLACS is considerably more expensive than standard cataract surgery and is not covered by MSP.

Another new technology is light-adjustable lenses. They are a type of artificial intraocular lens that allows vision to be fine-tuned in the weeks to months postcataract surgery using UV light.^{26,27} This may lead to greater patient satisfaction and has proven to be safe, but again, it is an expensive option and is not covered by MSP.^{26,27}

Conclusions

Cataract is an extremely common diagnosis that is most commonly associated with age. As the prevalence of cataracts continues to increase as the population in BC and Canada ages, it is important for all physicians to recognize the impact of this condition on patient lives. While cataracts cannot be prevented, onset can be delayed by advising smoking cessation, wearing sunglasses or hats for UVB protection, and managing diabetes.³⁻⁶ Once cataract progression is detrimental to a patient's quality of life, cataract surgery provides an extremely safe

and cost-effective mechanism for restoring vision. Ongoing technological advancements within the realm of cataract surgery help ensure that patients' independence, mental health, and even mortality rate are not negatively impacted by a cloudy lens. ■

Competing interests

None declared.

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Assessing the generalizability of finerenone trial criteria to a British Columbia population with type 2 diabetes in a community endocrinology setting

Considering the substantial health care burden of end-stage renal disease, integrating therapies like finerenone that reduce renal risk is essential, especially in populations with a higher prevalence of pre-existing cardiovascular disease.

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ABSTRACT

Background: Finerenone improves renal and cardiovascular outcomes in chronic kidney disease and type 2 diabetes, as demonstrated in the FIDELIO-DKD and FIGARO-DKD trials. The use of finerenone has recently been incorporated into Canadian guidelines. Previous studies have established the broad applicability of the FIDELIO-DKD and FIGARO-DKD inclusion criteria to international populations. We assessed whether these criteria similarly apply to an outpatient population at an endocrinology clinic in British Columbia.

Methods: We applied the FIDELIO-DKD and FIGARO-DKD enrollment criteria to determine

the proportion of patients in a community endocrinology practice who would meet trial-based eligibility criteria.

Results: Of 369 individuals with type 2 diabetes who were receiving standard of care treatment, 99 (27%) met FIDELIO-DKD or FIGARO-DKD enrollment criteria for residual cardiorenal risk. Their population characteristics were comparable to those in the inclusion trials: 65% male, mean age 71 years, A1c 7.9%, glomerular filtration rate 58 mL/min/1.73 m², urine albumin:creatinine ratio 32.2 mg/mmol, and systolic blood pressure 135 mm Hg. Our study population had a higher prevalence of prior myocardial infarction than those in the FIDELIO-DKD and FIGARO-DKD trials (26.2% vs 13.3% and 7.4%, respectively; $P < .05$).

Conclusions: In our study, 27% of individuals with type 2 diabetes had residual renal risk despite optimization. The higher proportion of patients in our study population who had pre-existing cardiovascular disease emphasizes the need for effective cardiorenal risk reduction among this population.

Background

Finerenone is a nonsteroidal mineralocorticoid receptor antagonist that has been shown to lower the risk of cardiovascular and renal events in people with type 2 diabetes and chronic kidney disease.¹⁻³

Despite evidence that finerenone reduced the risk of cardiovascular outcomes by up to 14% and renal outcomes by 23% across two phase 3 clinical trials (FIDELIO-DKD and FIGARO-DKD) and their pooled FIDELITY analysis, clinical uptake of finerenone remains low.¹⁻³ Given the substantial burden of cardiovascular and renal disease in patients with type 2 diabetes, we conducted a chart review in a community endocrinology practice in British Columbia to determine the proportion of patients who would meet finerenone trial criteria and potentially benefit from therapy.

Chronic kidney disease impacts up to 40% of people with type 2 diabetes, and diabetes mellitus remains the leading cause of end-stage renal disease in Canada and worldwide.^{4,5} Further, renal disease is an independent risk factor for cardiovascular disease among those with diabetes, and this population is more likely to experience death from a cardiovascular event before progressing to end-stage renal disease.^{6,7}

Management of chronic kidney disease in people with type 2 diabetes has classically been centred on the control of hypertension and hyperglycemia through the use of renin-angiotensin system (RAS) inhibitors and sodium-glucose transport protein 2 (SGLT2) inhibitors.⁸ Despite treatment, many people develop worsening renal function, resulting in residual cardiorenal

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risk, defined as the risk of progression of cardiovascular and/or renal events despite standard of care treatment.⁹

Development of cardiorenal disease has been associated with mineralocorticoid overactivation, which has resulted in the emergence of mineralocorticoid receptor antagonists in the management of chronic kidney disease associated with diabetes.¹⁰ The steroidal mineralocorticoid receptor antagonists spironolactone and eplerenone have been shown to significantly improve proteinuria in patients with chronic kidney disease; however, long-term data, particularly for people with type 2 diabetes who are receiving standard of care treatment, are lacking.¹⁰ Further, treatment with steroidal mineralocorticoid receptor antagonists is often limited due to side effects, including hyperkalemia and gynecomastia.¹¹

Compared with steroidal mineralocorticoid receptor antagonists, finerenone has been shown to have more potent anti-inflammatory and antifibrotic effects, with a more favorable side effect profile.^{2,12} Despite Health Canada’s approval of finerenone in October 2022, clinical uptake has remained slow, and Canadian guidelines have incorporated finerenone only within the past year [Table 1].¹³ In this study, we assessed the applicability of the FIDELIO-DKD and FIGARO-DKD inclusion criteria to a sample of British Columbia’s population within a community

endocrinology setting. A similar study done in the United States found that 2.2 million Americans would qualify for finerenone by clinical trial criteria.¹⁴

Compared with steroidal mineralocorticoid receptor antagonists, finerenone has been shown to have more potent anti-inflammatory and antifibrotic effects, with a more favorable side effect profile.

Methods

We performed a retrospective study in which we applied the FIDELIO-DKD and FIGARO-DKD inclusion criteria to a representative British Columbia population with type 2 diabetes optimized on standard care in a community endocrinology setting with a total census of 811 patients with type 2 diabetes. The study designs and enrollment criteria of the FIDELIO-DKD and FIGARO-DKD trials have been previously documented.^{1,2}

We performed a structured electronic medical record query to identify nonpregnant adults aged 18 years or older with type 2 diabetes who were receiving standard care,

defined as the use of maximum tolerated doses of RAS and SGLT2 inhibitors for a minimum of 4 weeks and 3 months, respectively. This was followed by manual extraction of selected variables. The enrollment criteria of the FIDELIO-DKD and FIGARO-DKD trials were then applied to this group. Patients were considered eligible if they met the criteria for either trial. In these criteria, chronic kidney disease was defined as a urine albumin:creatinine ratio (UACR) of 30 to 300 mg/g with a glomerular filtration rate (GFR) of 25 to 60 mL/min/1.73 m² or a UACR of 300 to 5000 mg/g with a GFR of 25 to 75 mL/min/1.73 m² as per the FIDELIO-DKD trial or a UACR of 30 to 300 mg/g with a GFR of 25 to 90 mL/min/1.73 m² as per the FIGARO-DKD trial.^{1,2}

In accordance with the two trials, we excluded patients with nondiabetic chronic kidney disease; A1c higher than 12%; uncontrolled hypertension with systolic blood pressure (SBP) of 170 mm Hg or higher; uncontrolled hypertension with diastolic blood pressure of 110 mm Hg or higher; hypotension with SBP of 90 mm Hg or lower; serum potassium of 4.8 mmol/L or higher; concomitant therapy with both ACE inhibitors and angiotensin receptor blockers; or concomitant therapy with eplerenone, spironolactone, any renin inhibitor, CYP3A4 inducers, or other potassium-sparing diuretics.

TABLE 1. Guideline recommendations for finerenone use in diabetic kidney disease.

Guideline	Population	Recommendation	Strength
Diabetes Canada	T2D + CKD (GFR 25–90 mL/min/1.73 m ²) with UACR 50–500 mg/mmol, on maximally tolerated RASi with serum potassium < 4.8 mmol/L	Finerenone recommended alongside potassium monitoring to reduce CKD progression and cardiovascular events.	Strong
Canadian Cardiovascular Society	T2D + CKD with high cardiovascular risk	Use of finerenone supported for cardiovascular risk reduction as an adjunct to guideline-directed therapy.	Moderate
Kidney Disease: Improving Global Outcomes (KDIGO)	T2D with GFR ≥ 25 mL/min/1.73 m ² , normal potassium, and albuminuria (UACR ≥ 30 mg/g) despite maximally tolerated RASi	Nonsteroidal MRA recommended if persistent albuminuria (UACR ≥ 30 mg/g) despite standard of care.	Grade 2A
American Diabetes Association	T2D with CKD and albuminuria (GFR ≥ 25 mL/min/1.73 m ²)	Nonsteroidal MRA recommended to reduce CKD progression and cardiovascular events. Monitor potassium 4 weeks after initiation.	Grade A

CKD = chronic kidney disease; GFR = glomerular filtration rate; MRA = mineralocorticoid receptor antagonist; RASi = renin-angiotensin system inhibitor; T2D = type 2 diabetes mellitus; UACR = urine albumin:creatinine ratio.

The demographic and clinical characteristics of our population were compared with those of the inclusion trial populations, and we assessed for statistical significance using the chi-square test.^{1,2}

Results

The FIDELIO-DKD and FIGARO-DKD trial criteria were applied to 369 individuals with type 2 diabetes who were receiving standard of care treatment with RAS and SGLT2 inhibitors; 99 (27%) met trial criteria for initiation of finerenone.

The characteristics of our study and inclusion trial populations are outlined in Table 2. The demographic profile of our cohort that was eligible for finerenone closely resembled that of the trial populations, with 65% being male and a mean age of 71 years. Renal function parameters were also comparable, with mean GFR of 58 mL/min/1.73 m², median UACR of 32.2 mg/mmol, mean serum potassium of 4.58 mmol/L, and mean SBP of 135 mm Hg. In our population, 43 individuals (43%) had moderately increased albuminuria, 18 (18%) had severely increased albuminuria, and 18 (18%) had potassium levels of 5.0 mmol/L or higher. The median duration of type 2 diabetes in our population was 17 years, with a mean A1c level of 7.9%. In

the population that was eligible for finerenone, 44 (44%) were being treated with a glucagon-like peptide-1 (GLP-1) receptor agonist.

In terms of complications, our study population exhibited a higher prevalence of prior myocardial infarction compared with individuals in the FIDELIO-DKD and FIGARO-DKD trials (26.2% vs 13.3% and 7.4%, respectively; $P < .05$). However, the prevalence of stroke in our cohort (12.1%) was comparable.

Despite Health Canada's approval of finerenone, its adoption into clinical practice remains slow.

In our study, the main reasons why individuals with type 2 diabetes who were receiving standard care did not meet the eligibility criteria for initiating finerenone included the absence of a UACR, suboptimal optimization with RAS or SGLT2 inhibitors, or chronic kidney disease attributed to causes other than type 2 diabetes.

Discussion

Finerenone was approved by Health Canada in October 2022, but Canadian guidelines have only recently recommended its use in reducing cardiorenal risk.¹³ Despite Health Canada's approval of finerenone, its adoption into clinical practice remains slow. Similarly, the American Diabetes Association guidelines endorse a Grade A recommendation for finerenone for those with chronic kidney disease and type 2 diabetes at elevated risk.¹⁵ A comprehensive overview of guideline recommendations for finerenone use is outlined in Table 1. Studies have demonstrated the broad generalizability of the FIDELIO-DKD and FIGARO-DKD trial criteria to the US population.¹⁴ Chiu and colleagues reported that 2.2 million patients in the US who had type 2 diabetes and were on RAS therapy met initiation criteria for finerenone by at least one full trial criterion, which highlights significant potential for its clinical application.¹⁴

We similarly demonstrated the applicability of these trial criteria to our study population. Renal function in our participants was between that observed in the FIDELIO-DKD and FIGARO-DKD trials, with GFR that was intermediate to the advanced renal impairment in the

TABLE 2. Demographics of patients eligible for finerenone based on the FIDELIO-DKD and FIGARO-DKD inclusion trials compared with US and Canadian studies.

	FIDELIO-DKD	FIGARO-DKD	Chiu and colleagues ¹⁴ (US)	Current study (Canada)	P value
Age (mean, years)	65.40	64.10	67.00	70.83	—
Sex: male (%)	68.9	68.6	58.5	64.6	.896
Sex: female (%)	31.1	31.4	41.5	35.4	.896
Systolic blood pressure (mean, mm Hg)	138.1	135.8	138.2	135.3	—
Diastolic blood pressure (mean, mm Hg)	75.8	76.8	68.5	75.3	—
A1c (mean, %)	7.7	7.7	7.6	7.9	—
Glomerular filtration rate (mean, mL/min/1.73 m ²)	44.4	67.6	65.7	57.6	—
Urine albumin:creatinine ratio (median, mg/mmol)	83.3	30.2	11.0	32.2	—
Serum potassium (mean, mmol/L)	4.37	4.33	4.10	4.58	—
Myocardial infarction (%)	13.3	7.4	10.9	26.2	< .001
Stroke (%)	11.6	12.0	11.7	12.1	.490

FIDELIO-DKD trial and the milder impairment in the FIGARO-DKD trial. However, our study population differed notably from the inclusion trial populations by having a higher prevalence of background cardiac disease. This may have been due to the advanced age of our cohort compared with that of the inclusion trial cohorts, or to background SGLT2 use, which may reflect more advanced disease and a higher cardiovascular risk profile. Evidence from the FINE-HEART trial, which demonstrated reductions in heart failure hospitalizations, cardiovascular events, and all-cause mortality with finerenone, supports its potential benefit in higher-risk populations that are similar to our study cohort.¹⁶

Our study population included patients who were already optimized on SGLT2 inhibitors. This criterion was more restrictive compared with the inclusion trials, which required optimization only on RAS inhibitors. Additionally, nearly half of our eligible participants were also receiving GLP-1 therapy, agents that also demonstrate renal benefit, according to recent studies such as the FLOW trial.¹⁷ The CONFIDENCE trial showed that simultaneous initiation of finerenone and empagliflozin led to a 52% reduction in UACR at 180 days, which outperformed finerenone (29%) and empagliflozin (32%) alone.¹⁸ Despite optimization with these additional agents, many patients in our study still met the eligibility criteria for initiating finerenone.

The cost of finerenone is estimated to be \$1200 to \$1300 per year without private drug coverage.¹⁹ In BC, finerenone is covered for individuals with type 2 diabetes and chronic kidney disease who remain at elevated risk of disease progression despite optimized standard therapy.²⁰ The full PharmaCare Special Authority eligibility criteria are outlined in the **Box**.

In conclusion, our study highlights the applicability of FIDELIO-DKD and FIGARO-DKD trial criteria to a British Columbia context and emphasizes the ongoing need for proactive management strategies in patients facing residual renal risk despite optimized therapy.

BOX. British Columbia PharmaCare finerenone eligibility criteria.

Finerenone may be used as an adjunct to standard of care therapy to reduce the risk of end-stage renal disease and sustained decrease in glomerular filtration rate (GFR), as well as cardiovascular death, nonfatal myocardial infarction, and hospitalization for heart failure in an adult patient who meets all the following criteria:

- The patient has both type 2 diabetes and chronic kidney disease with a GFR of at least 25 mL/min/1.73 m².
- The patient has albuminuria of at least 3 mg/mmol or 30 mg/g.
- The patient is receiving maximally tolerated doses of both ACE inhibitors or angiotensin receptor blockers *and* sodium-glucose cotransporter 2 inhibitors.
- The patient does *not* have New York Heart Association class II–IV heart failure.
- The patient is *not* on concurrent treatment with a different mineralocorticoid receptor antagonist.
- Treatment has been prescribed by a health care professional who has experience in the diagnosis and management of patients with type 2 diabetes and chronic kidney disease or in consultation with a nephrologist.

Adapted from the BC Ministry of Health website.²⁰

Considering the substantial health care burden of end-stage renal disease, integrating therapies like finerenone that reduce renal risk is essential, especially in populations with a higher prevalence of pre-existing cardiovascular disease. ■

Competing interests

Dr Jazdarehee has no competing interests to declare. Dr Shu has received speaking fees and advisory consulting fees from Boehringer Ingelheim, Bayer, Eli Lilly and Company, and Novo Nordisk. Dr Jain has received grants/research support from Abbott, Amgen, AstraZeneca, Eli Lilly and Company, Novo Nordisk, Roche, and Sanofi; speakers bureau/honoraria from Abbott, AbbVie, AstraZeneca, Amgen, Antibody Healthcare Communications (now part of Dentsu Health), Bausch Health, Bayer, Boehringer Ingelheim, Care to Know, Collaborative CME and Research Network, CPD Network, Dexcom, Diabetes Canada, Eli Lilly and Company, Embecta, eoci Health, GSK (formerly GlaxoSmithKline), HLS Therapeutics, Janssen, Liv Labs, Master Clinician Alliance, MDBriefCase, Merck, Medtronic, Moderna, NP Circle, Novartis, Novo Nordisk, Partners in Progressive Medical Education, Pfizer, Roche, Six Degrees Medical, TimedRight, Unik, and WebMD; and

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Patient portals and radiology reports: Toward patient-centred communication

As patient portals expand direct access to radiology reports across Canada, design-focused interventions, such as plain-language summaries and contextual glossaries, can bridge the gap between report access and patient understanding, promoting health equity.

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The widespread adoption of patient portals—digital interfaces that provide patients with direct access to their electronic health records—has given patients easier access to their radiology reports. Medical imaging reports are

now accessible via patient portals in British Columbia, Alberta, Saskatchewan, Ontario, and Quebec. BC's primary patient portal, Health Gateway, grew from 350 registered users in 2019–2020 to 1.63 million in 2024–2025, the highest portal uptake rate among Canadian provinces.^{1,2} This expansion represents meaningful progress toward transparency and patient-centred care. While radiology reports initially served as a clinician-to-clinician communication tool, they are now accessible to patients, decentralising health information. However, shifting radiology reports to this new audience comes with implications for how patients interpret their imaging results and navigate follow-up care.

A new audience for radiology reports

While patient portals have enhanced access, transparency, and patient engagement, they have also introduced an unintended patient-facing role for radiology reports, highlighting the limitations of documentation that was not originally designed for a patient audience. Radiology reports were designed as clinician-to-clinician communication tools, summarizing imaging findings for referring clinicians with specialized terminology, structured reporting conventions, and probabilistic language. Their primary function has been to support diagnostic reasoning and care planning. With patient portals in place, these clinician-oriented reports are available to patients approximately 7 days after the related procedure.³ Although BC has one of the shortest wait

times across Canada from referral initiation to specialty care—a median of 59 days⁴—this timing means that patients often view their reports before having an explanatory discussion with their clinician. This gap between accessing a report and having a clinical discussion may heighten patients' anxiety, disproportionately impact patients with limited health literacy, and drive increased reassurance-seeking behaviors.

Why radiology reports are difficult for patients to interpret

For many patients, radiology reports are challenging to interpret because they rely on specialized terminology and clinical reasoning that assume professional training. In a readability analysis of over 97 000 radiology reports, Martin-Carreras and colleagues found that only 4.2% were written at or below the average adult reading level,⁵ indicating that interpreting most reports requires advanced literacy. Phrases such as “correlate clinically,” “differential diagnoses,” and “cannot exclude” have precise meanings to clinicians but may cause confusion or concern for patients. Findings that are clinically routine can be misinterpreted or perceived as alarming when viewed without timely clinical interpretation, affecting how patients navigate follow-up care.

Unintended challenges

Patients in BC often encounter their radiology reports for the first time without the benefit of real-time clinical interpretation. The Ministry of Health acknowledges that

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PREMISE

“[w]hile it is reasonable to expect that the release of some imaging results will cause patient anxiety, . . . the waiting associated with an unknown result also causes anxiety,” with patient advocates advising that the benefits outweigh the risks.⁶ A key need is to better understand how patients interpret the radiology reports they access through patient portals.

Patients’ emotional responses to portal-accessed radiology reports vary widely, shaped in part by differences in their level of education and health literacy. In one study of 361 patients reviewing radiology-exam informational documents, those with a university degree reported a higher objective understanding than those without (72% vs 48%).⁷ Patients with a lower understanding of radiology reports experience higher anxiety compared with those with a better understanding, often linking poor comprehension to increased emotional distress, confusion, and unnecessary worry.⁸ Supporting diverse educational needs is essential to ensure that the benefits of patient portals are equitably realized.

Improving patients’ understanding of their radiology reports is also important to support effective follow-up care. When patients misinterpret unfamiliar terminology or ambiguous findings, they may develop expectations that do not align with the clinical significance of the results, complicating subsequent conversations and decision making. One study provided 20 laypeople with a CT report and asked them to reflect on it as if they were the patient receiving the report. Eighty-five per cent of participants reported being confused, reporting that they would feel fear and anxiety if they received the report. When asked to describe their next steps, they reported needing additional clarification.⁹ This study suggests that poor understanding and anxiety prompt patients to seek clarification from emergency departments or multiple providers, adding strain to the system. Canadian research has further demonstrated that low health literacy is associated with increased nonurgent emergency department use and preventable admissions.¹⁰ Enhancing comprehension

strengthens both the patient’s experience and clinical efficiency, emphasizing the value of supporting patients as they navigate radiology information.

Advancing patient-centred communication in radiology

Improving patients’ understanding of radiology reports does not necessarily require radiologists to change how they document findings, nor does it require patients to seek additional care. Instead, design-focused strategies can enhance comprehension while preserving the clinical accuracy and workflows of traditional reporting.

Portals can incorporate layered information structures, where the full clinician-facing report remains unchanged but is paired with a brief, automatically generated, patient-friendly summary that explains the main findings in plain language. Large language models (LLMs) have shown promise for improving comprehension by generating simplified reports in patient-friendly language [Table].¹¹ In a US national study of 2000 adults, participants who received LLM-generated plain-language radiology reports demonstrated significantly

higher accuracy in comprehension (68.0% vs 58.0%; marginal difference of 10.8%) and follow-up understanding (64.5% vs 58.4%; marginal difference of 6.8%) compared with those who received traditional reports.¹² Critically, improvements were larger among participants older than 44 years of age and those with lower than a college education. This differential benefit pattern illustrates how LLM-assisted interventions can reduce comprehension disparities.

While reviewing LLM-generated summaries is currently the responsibility of the supporting clinician to ensure accuracy and safety, employing technical safeguards supports implementation. Constrained models that restrict the structure and content of LLM outputs through predefined templates or rules, combined with retrieval-augmented generation that draws on curated medical sources, may reduce the additional burden. A systematic review and meta-analysis of biomedical applications reported a 1.35 odds ratio increase in performance metrics such as accuracy and completeness relative to baseline LLM systems,¹³ potentially enabling safer implementation while reducing the need for extensive manual review.

TABLE. Example radiology report showing the clinician-facing report alongside a layperson summary generated by large language models (LLM).

Radiology report ¹¹	LLM-generated summary
Procedure reported: Film screen mammography, both breasts.	Test: Mammogram of both breasts.
Reason for procedure: Screening.	Why the test was done: Routine breast cancer screening.
Comparison to previous exams: Comparison was made to exam from 11/14/2001.	Comparison: Compared with your previous mammogram from 14 November 2001.
Breast composition: The breasts are heterogeneously dense. This may lower the sensitivity of mammography.	Breast tissue: Your breast tissue is dense, which is common, but it can make it slightly harder for mammograms to detect small changes.
Findings: No significant masses, calcifications, or other abnormalities are present. There is no significant change from the prior exam.	Results: No abnormal lumps, suspicious calcium deposits, or other concerning findings were seen. The images look similar to your previous mammogram, with no important changes.
Impressions: BI-RADS® Category 1: Negative. Recommend normal interval follow-up in 12 months.	Conclusion: Your mammogram is normal.
Overall assessment: Negative.	Next steps: Continue routine screening with another mammogram in 12 months.

Embedding definitions for common radiologic terms, such as *atelectasis*, *effusion*, or *indeterminate*, through hover-over functions or clickable links can also help patients interpret unfamiliar terminology without initiating additional clinical encounters. Standardized explanations for phrases expressing diagnostic uncertainty, including “clinical correlation required” or “cannot exclude,” may further reduce misinterpretation. Incorporating these lay language summaries and glossaries directly into existing reports has been shown to have the greatest impact on patient understanding.⁸ A systematic review has further demonstrated that these interventions have resulted in greater improvements in disadvantaged populations compared with those with higher literacy levels.¹⁴ By adopting design features that support patient understanding while preserving the integrity of clinical documentation, health systems may promote patient well-being, health literacy equity, and system efficiency.

Emerging LLM tools are beginning to appear in BC’s radiology workflows. Vancouver Coastal Health is a core partner in Iris, described as Canada’s first artificial intelligence co-pilot for diagnostic imaging, which integrates natural-language processing tools to support quality assurance, patient monitoring, and follow-up.^{15,16} Nationally, the Canadian Association of Radiologists is leading the Healthcare AI Validation Network,¹⁶ which evaluates LLM-enabled tools on Canadian data before broad deployment, and BC sites are expected to participate in these evaluations.

Conclusions

Radiology reports in the patient portal era reflect a broader shift toward openness in health care, offering patients unprecedented access to information that was once available only through clinicians. Yet access alone does not ensure understanding. The technical language, conditional phrasing, and timing of report release can create anxiety for many patients, particularly when results are viewed without contextual interpretation. It can also cause reassurance-seeking

behaviors, adding strain to an already overburdened health care system. Through thoughtful design-focused portal modifications leveraging LLMs, we can enhance how patients understand their imaging results and navigate follow-up care. As patient portals continue to expand, aligning access with understanding will be essential to ensure that transparency benefits the patients it aims to empower. ■

Competing interests

None declared.

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Universal screening for hepatitis C during pregnancy: An opportunity to advance viral hepatitis elimination in British Columbia

As 28 July is World Hepatitis Day, it is an opportune time to share the Society of Obstetricians and Gynaecologists of Canada's (SOGC's) recent recommendation for universal hepatitis C virus (HCV) screening in the first trimester of every pregnancy.¹ This guidance reflects a major shift from previous risk-based approaches and aligns prenatal screening with broader efforts to eliminate HCV as a public health threat by 2030.

Chronic HCV infection remains a leading cause of cirrhosis, hepatocellular carcinoma, and liver-related mortality in BC and across Canada. Although highly effective direct-acting antiviral therapies can now cure more than 95% of infections, many people with chronic HCV infection remain undiagnosed or face other barriers to engaging in care and treatment. Pregnancy provides an important opportunity to identify individuals with HCV who may otherwise not be engaged in testing or care. Perinatal transmission of HCV occurs in approximately 5% of pregnancies involving active maternal infection. Although many exposed infants will not develop chronic infection, those who do are at risk of long-term liver disease and may remain undiagnosed without follow-up testing.

Historically, prenatal HCV screening has been initiated primarily through identification of risk factors. However, recent evidence from Alberta has demonstrated

that risk-based screening misses many HCV infections among people without recognized or disclosed risk factors.² Prenatal HCV screening uptake in BC is already relatively high, with 54.6% of prenatal patients screened for HCV in BC in 2019. However, the proportion of positive prenatal HCV antibody (anti-HCV) tests in BC (0.36%) was approximately 5 times that reported in Alberta (0.07%) during a similar period.³ This suggests that HCV infection during pregnancy may be considerably more common in BC, further underscoring the importance of universal prenatal screening here.

The SOGC now recommends that HCV screening occur during first-trimester prenatal testing or at the first antenatal visit. Positive anti-HCV results should be followed by HCV RNA testing to determine active infection. For pregnant people with previously documented anti-HCV positivity, repeat antibody testing is not recommended, because antibodies remain positive lifelong, even after cure; HCV RNA testing should instead be used to assess active infection. Further guidance on HCV management during pregnancy and recommended follow-up for infants exposed to HCV perinatally is available from Perinatal Services BC.⁴

Several provincial systems and resources have been updated to support implementation of universal prenatal HCV screening in BC. The BC Centre for Disease Control (BCCDC) Public Health Laboratory has added anti-HCV to its routine prenatal screening panel and updated its Serology Screening Requisition, which can be accessed through the BCCDC website or

the *eLab Handbook*.^{5,6} Clinicians should note that some older forms available through Internet searches may not reflect these updates. Perinatal Services BC's online guidance on laboratory tests to order by trimester now also indicates that HCV screening is recommended for all pregnancies.⁷ Although the BC Ministry of Health's Standard Out-Patient Laboratory Requisition for Maternity Care was updated in January 2026, revisions were finalized before publication of the new SOGC guidance, so anti-HCV remains listed under "Recommended tests based on risk factors."⁸ Revisions to align that form with universal prenatal HCV screening are anticipated in the next update, planned for January 2028.

Universal prenatal HCV screening will be critical to achieving HCV elimination in BC. By embedding HCV testing in routine prenatal care, clinicians can help identify undiagnosed infections earlier, improve linkage to curative treatment, and reduce missed opportunities for prevention and follow-up care for both parents and their infants. ■

—Sofia R. Bartlett, PhD
Scientific Director (Interim), Clinical Prevention Services, BCCDC

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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.

The missing link in reproductive care: Overcoming the vasectomy access crisis in BC

In April 2023, BC became the first Canadian province to offer universal coverage for prescription contraceptives. It was a landmark achievement for reproductive justice, saving residents hundreds of dollars annually and removing financial barriers to the birth control pill, IUDs, and emergency contraception.¹ This policy was hailed as a significant step toward gender equity, yet a disparity remains.

While a “permanent” procedure like a vasectomy is not exactly equivalent to reversible short- or long-acting contraceptives, it remains a cornerstone of male contraception that, when properly supported, ensures that the lifelong responsibility for family planning is a shared commitment rather than a solo female obligation. Currently, male contraception faces a crisis of access, cost, and systemic neglect that undermines the equity the province sought to achieve.

Despite vasectomy being covered by the Medical Services Plan (MSP), the path to obtaining a vasectomy in BC is increasingly fraught with obstacles. In many regions, urologists have shifted away from performing vasectomies for various reasons, including poor compensation, leaving a significant void in access to the procedure. While some family physicians do perform vasectomies, it is not enough to meet demand, resulting in prolonged wait lists.

This bottleneck forces many individuals into a difficult position—wait indefinitely in the public system or seek care at private clinics. These clinics, while offering faster access, often opt out of the public billing system or charge significant administration fees or premiums that are not covered by MSP.² By universally funding female contraception while gating vasectomies behind high costs and long wait lists, the system reinforces that the mental and physical burden of contraception is a female obligation rather than the shared responsibility it ought to be.

Beyond the logistic and financial hurdles lies a deeper, more pervasive social inequity. This disparity reflects a deeply ingrained contraceptive burden placed on females. Research indicates that approximately 70% of individuals believe their social environment expects women to take responsibility for pregnancy prevention.³ Even in clinical settings, the mental and emotional labor of managing fertility is often constructed as “the woman’s job,” while the male role remains passive.⁴ By failing to subsidize and streamline male contraception with the same vigor as female methods, the system reinforces the outdated idea that family planning is a woman’s responsibility.

Many men are willing and eager to share the responsibility of family planning. For men to be active partners in this conversation, the system must remove structural barriers that penalize male participation.

The failure to streamline male contraception also has economic implications. In BC, an unintended pregnancy resulting in a birth is estimated to cost the health care system over \$8100; therefore, providing universal contraception for females is

projected to save the province \$27 million annually by its fourth year.⁵ Expanding this logic to include male contraception would further reduce these costs.⁶

By failing to fund and support a robust public network of vasectomy providers, the government is missing a critical opportunity to further reduce the rate of unintended births and their associated long-term social and economic costs. Until BC addresses the long wait lists and the private-pay barrier for vasectomies, the burden of contraception will remain unfairly, and inefficiently, shouldered by women. ■

—Alex Kilpatrick, MD, MPH, CCFP
Council on Health Promotion Member

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This article is the opinion of the authors and not necessarily the Council on Health Promotion or Doctors of BC. This article has not been peer reviewed by the BCMJ Editorial Board.

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 Kevin Beckner 1972–2026

Dr Kevin Beckner was a keystone in the architecture of his family and community. He was resolute, grounded, and calm—a deeply caring man of integrity, kindness, and depth.

Despite his astronomical impact on family, friends, and colleagues, Kevin preferred to let others have the limelight. He was nonjudgmental and found common ground with anyone. People often learned something about themselves in conversation with him.

Salmon Arm was in Kevin's bones. He left after high school to study at the University of Victoria, where he earned an honors degree in biochemistry, followed by UBC medical school in Vancouver. His radiology residency took him to Kingston, Ontario, where he and Suzy bought their first home and started their family. When they returned to BC, Kevin worked as a radiologist at Royal Inland Hospital in Kamloops for 4 years. Then they moved to Salmon Arm, made it their forever home, and sank in thoroughly.

Kevin worked for the BC Wildfire Service for 3 seasons during medical school, joining the Telkwa Rangers Unit Crew in 1996. He became a skilled saw operator and tree faller and a trusted crew member known for hard work and diligence. This is where he met Suzy, working alongside her on her squad. Kevin and Suzy built a strong, supportive partnership filled with adventure and a large, tight-knit friend group.

Kevin was fiercely proud of their children, Maggie and Max, and avidly supported everything they pursued. He would drive 7 hours to watch a hockey tournament or ski race, even when he had to work the next day. He coached Max's hockey teams, from novice to bantam, often showing up early to feed the keeners the puck. He would pick up anyone who needed a ride and always made a Tim Hortons pit stop after the 6:30 a.m. practice.

Kevin also loved his work family at Shuswap Lake General Hospital. During his 17 years in the radiology department, he was the guy you could go to with questions or to run a case past. He made time, and if he didn't have the answer, he'd find it.

He was a mentor, teacher, and steadfast leader. Kevin dedicated his medical career to diagnostic radiology, combining clinical excellence with thoughtful, steady leadership. In June 2018, he became medical director of Interior Health medical imaging, providing oversight and strategic direction for one of the most complex clinical programs in the region. He worked with clinical, operational, and executive leaders to support high-quality, safe, and equitable diagnostic imaging services across urban, rural, and remote communities.

As medical director, Kevin was respected for his calm judgment, collaborative

leadership, and deep understanding of both frontline clinical realities and system-level responsibilities. He was a trusted voice on quality, safety, physician engagement, and workforce sustainability, and he advocated for solutions that balanced clinical excellence with compassion for colleagues and patients alike. His leadership helped strengthen medical imaging as a cohesive, regionally integrated program, even during significant system change and pressure.

He served as chief of radiology at Shuswap Lake General Hospital and sat on the facility engagement working group for years, because he was vigilant about quality improvement and patient care. His research and advocacy were instrumental in the purchase of new hospital equipment and technological upgrades.

Throughout his career, Kevin remained first and foremost a clinician, serving at Royal Inland Hospital from 2005 to 2009 and at Shuswap Lake General Hospital from 2009 to 2026. He was known as a generous mentor, a fair and thoughtful leader, and a physician who never lost sight of the human impact of the work.

All staff, regardless of their position or role, considered Kevin a friend. He asked questions about people's lives and listened with genuine interest. He paid attention to what they valued and who mattered to them. And he remembered.

Kevin will be deeply missed by his wife, Suzy; children, Maggie and Max; parents, Marcia and Jim; brother, Michael (Pauline); nephews, Dane, Owen, and Will; sister-in-law, Laura Tayler-Hanson (Ryan); nieces, Teslin, Tlell, and Teagan; parents-in-law, James and Margaret Tayler;

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Why does my patient continue to hurt?

As a family physician in primary care, you may encounter patients with soft-tissue injuries who do not recover as expected following a low-energy injury in a workplace setting—for example, a 33-year-old mechanic who has been away from work with lower-back pain for several months after reaching forward too far for a screwdriver.

Diagnostic clarification, natural history, and optimizing function are key considerations when assessing such patients.

For the mechanic, you might initially diagnose him with a quadratus lumborum sprain or strain given the low-energy mechanism and clinical findings: local muscle tenderness and normal neurologic exam. At that time, you recommend a few days of rest and a course of physiotherapy. He, however, reports ongoing back pain and remains off work 2 months later. At this stage, you begin reconsidering diagnosis and management, as prolonged disabling pain is not typical for most soft-tissue injuries at 2 months.

WorkSafeBC can help with diagnosis, treatment, and specialized programs

If you are uncertain about diagnosis

For medical imaging, WorkSafeBC can consider expediting MRI and CT scans if you complete and fax the Requisition for Medical Imaging and Interventional Procedures (Form 83D56) to us, available on www.worksafebc.com. Expedited image-guided diagnostic injections are also available via the Requisition for Expedited Image-Guided Diagnostic and Therapeutic

Injections (Form 83D58). If your request is approved, we will refer your patient to our network of providers.

For specialist assessments, WorkSafeBC operates the Visiting Specialist Clinic in Richmond. You may request a referral to this clinic on the Physician's Report (Form 8/11).

WorkSafeBC has access to specialized treatment programs, such as pain and medication management, customized recovery and return to work, and return to work support services, to help you manage psychosocial and occupational factors.

If your request is approved, a WorkSafeBC physician will write the referral on your behalf, and you will receive a copy of the consultation report.

You may also refer to a specialist in your community who accepts expedited referrals for WorkSafeBC-related injuries. Consult Pathways (<https://pathwaysbc.ca>) to see which specialists do.

If other factors are affecting recovery

If you are certain about the diagnosis and your patient is still not improving with standard treatment under the biomedical model, consider inquiring about other factors that may be affecting recovery, including:

- Psychological factors (e.g., depression, anxiety, substance use).
- Social factors (e.g., stressful life events, social isolation, lack of support from family or community).
- Occupational factors (e.g., problems at work, such as interpersonal conflict or grievances; availability of modified work or accommodation; lack of support from supervisor and co-workers).

Screening for these factors (e.g., with the Patient Health Questionnaire-9 or the Generalized Anxiety Disorder-7) may help prevent your patient from experiencing additional disability.

WorkSafeBC has access to specialized treatment programs, such as pain and medication management, customized recovery and return to work, and return to work support services, to help you manage psychosocial and occupational factors. If you think your patient would benefit from one of these programs, please state this on the Form 8/11 or discuss it with a WorkSafeBC physician.

Connecting with WorkSafeBC

- WorkSafeBC physicians are available to discuss diagnoses and recovery and to provide advice about WorkSafeBC programs. You can request a discussion on Form 8/11 or via the RACE app (www.raceconnect.ca/get-raceapp).
- You can also search the WorkSafeBC specialty on Pathways for information on specialist referrals, mental health, and WorkSafeBC health care programs.
- For more resources for primary care, including the full list of rehabilitation and other services supported by WorkSafeBC, visit www.worksafebc.com/physicians and www.worksafebc.com/primary-care.

This article is the opinion of WorkSafeBC and has not been peer reviewed by the BCMJ Editorial Board.

It is also important to consider that while nociception is a final common pathway of many pathophysiological processes that require thoughtful analysis and reanalysis, pain is experiential, and everyone experiences pain differently. Acknowledging and respecting that perspective does not preclude you from optimizing your patient's function.

Progressive restoration of function and participation in life roles is a widely studied modality with a plethora of benefits when applied with care and safety in mind.¹ You can support your patient by providing reassurance (e.g., on hurt versus harm) and prescribing an activation program, with assistance from WorkSafeBC community-based occupational therapy and physiotherapy programs. (Indicate your request for this service on Form 11.) To support modified work duties for your patient while they continue to recover, you can acknowledge and describe the worker's current abilities in relation to functional activities and, if necessary, prescribe restrictions to prevent harm.

WorkSafeBC can also facilitate the return-to-function process by assisting family physicians in understanding the legal duty for employers and injured

workers to actively cooperate in the worker's timely, safe return to work, as outlined at www.worksafebc.com/returntowork.

Returning to the mechanic, you recognize that his recovery is not progressing as expected, and you bring him in for review. He tells you that he is worried there is a more serious problem with his back and that he does not trust his employer to support modified duties based on his co-workers' experiences. You send your patient for a lumbar X-ray, and the results are normal. You speak with a WorkSafeBC physician about the patient's concerns and his fear of another injury (despite the reassuring X-ray). WorkSafeBC arranges a Visiting Specialist Clinic orthopaedic assessment on your behalf and engages its return-to-work support services to arrange modified duties. Your patient completes his recovery at work. ■

—Harvey Koochin, MD

Manager, Medical Services, WorkSafeBC

—A. Somani, MD, CCFP

Manager, Medical Services, WorkSafeBC

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and a large circle of extended family, friends, and colleagues.

Kevin's legacy lives on through the physicians, technologists, leaders, and staff he supported; the program he helped steward; and the patients who benefited from his expertise and dedication.

Donations may be made to the Shuswap Hospital Foundation in memory of Kevin Beckner. ■

—Tamara Vukusic

Kamloops

BCCDC

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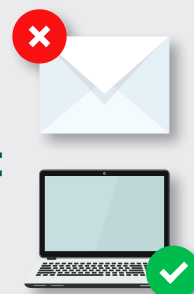
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9th Annual Virtual Fertility Symposium

OCTOBER 21, 2026 | 12:00 – 4:30 PM | VIRTUAL VIA ZOOM



Join us for an afternoon of expert-led education at PCRM's 9th Annual Fertility Symposium — a free, virtual event designed for healthcare providers and fertility professionals across Canada.

This year's program will cover a range of topics in reproductive medicine, including:

- Male infertility
- Endometriosis
- Polyendocrine Metabolic Ovarian Syndrome (PMOS) - formerly PCOS
- Menopause and reproductive aging



Admission is free. Registration is required.

To reserve your spot, email CME@pacificfertility.ca or scan the QR code.