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 syndrome[3] 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, FRCSC
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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Barraquer Comes A, Roy Millán P. Proton pump inhibitor deprescription prospective study in patients without indication: Are there differences in proportion of restarts according to withdrawal strategy? J Pharm Technol 2023;39:224-230. https://doi.org/10.1177/87551225231195216.

Namikawa K, Björnsson ES. Rebound acid hypersecretion after withdrawal of long-term proton pump inhibitor (PPI) treatment—Are PPIs addictive? Int J Mol Sci 2024;25:5459. https://doi.org/10.3390/ijms25105459.

Reimer C, Søndergaard B, Hilsted L, Bytzer P. Proton-pump inhibitor therapy induces acid-related symptoms in healthy volunteers after withdrawal of therapy. Gastroenterology 2009;137:80-87. https://doi.org/10.1053/j.gastro.2009.03.058.

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 trial[1] 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 colleagues[2] 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 colleagues[1] 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 colleagues[3] 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 colleagues[4] found only two studies that supported RAHS—Reimer and colleagues[1] 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 AGA[5-7] 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.

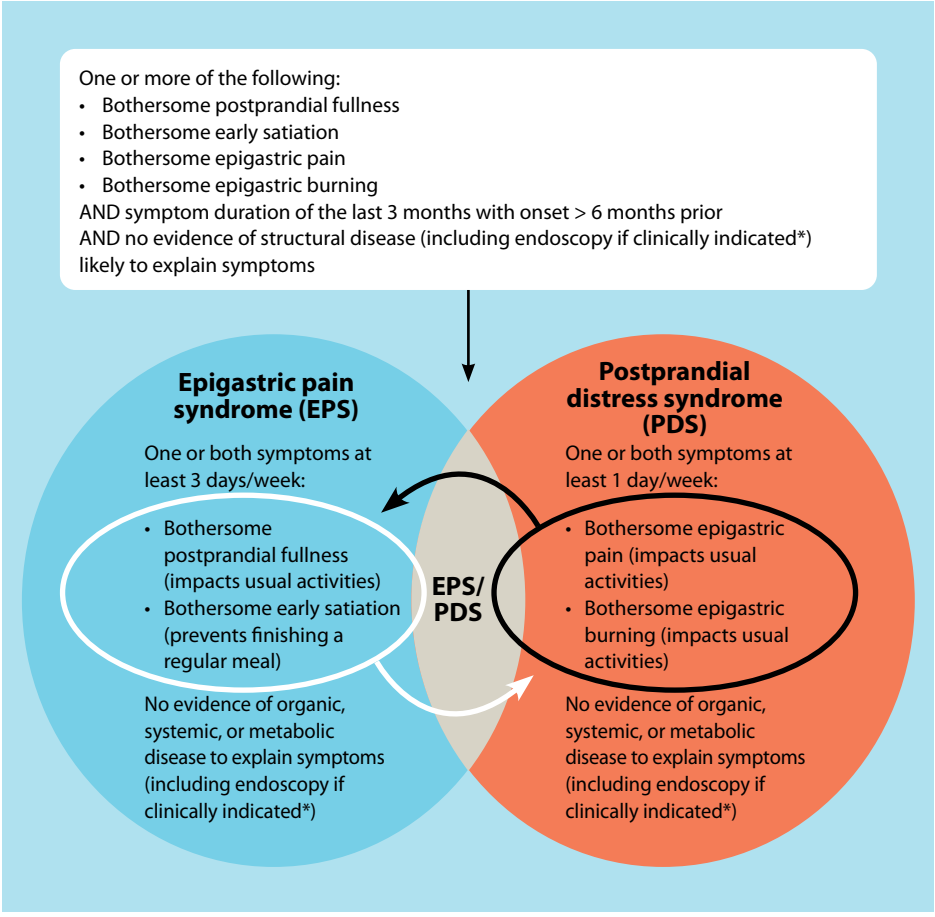

FIGURE 2. Rome IV criteria for functional dyspepsia. Adapted from the Rome IV criteria for functional dyspepsia, with supportive features for postprandial distress syndrome (PDS)/epigastric pain syndrome (EPS) excluded[21] and endoscopic investigation recommended only if clinically indicated as per the 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]

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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