Letters to the editor

We welcome original letters of less than 500 words; we may edit them for clarity and length. Email letters to journal@doctorsofbc.ca and include your city or town of residence, telephone number, and email address. Please disclose any competing interests.

Bravo for *BCMJ* cover art

As a longtime reader of the *BC Medical Journal*, I have always appreciated the appropriate and often whimsical artistic representation of the lead articles. With the FIFA tournament afoot, the cover illustration's depiction of the brain, the youth's body language, and the soccer ball by the bed were timely for the June 2026 issue!

Interestingly, the illustration also applies to other content in the issue that concerns brain health: permanent daylight saving time, fetal alcohol spectrum disorder and incarcerated people, young men's health, medication abortion, burnout, environmental history taking, and community health care!

Bravo to the artists and editors who have made these illustrations relevant and educational.

—Kwadwo Ohene Asante, MSM, BSc, MBChB, FRCPC
New Westminster

Re: Appropriate use of diagnostic tests in medical practice

It has been some time since I practised medicine actively, but I think there is some nuance required in the statement "It is not a sufficient justification to order a test solely to satisfy one's curiosity or to alleviate anxiety if the evidence does not support its use" [*BCMJ* 2026;68:141-144].

Stewardship of limited resources is the responsibility of everyone in the health care system. There can be and are different perspectives on what responsible decisions are. Evidence-based decisions are ideal but often lack precision and can be poorly informed. Curiosity is the foundation of clinical care—without it, differential diagnoses are not possible, and an evolving worldview is stymied. Algorithmic care, perhaps in the future mediated by artificial intelligence, may have value, but it will not replace the human side of medicine or substitute the need of physicians to advance their perspectives. Trust and human relationships remain the foundation of clinical care. Managing complexity and uncertainty remain the most challenging aspects of providing care. Therefore, I disagree. Curiosity is the *only* reason to order a diagnostic test; everything else is superfluous, even if alternative considerations are important.

As an example, my father-in-law recently died of metastatic cancer. His ordeal started when he complained of pain and disability in his right hip sufficient to stop working and to interfere with his responsibilities as a caregiver at home. His family doctor attributed his symptoms to trochanteric bursitis. However, despite time and treatment for bursitis, his symptoms worsened. Eventually, a diagnosis of metastatic cancer was made after an emergency admission and a CT scan. He died shortly after.

From my perspective, failed treatment is an indication for timely advanced investigations—curiosity and urgency—especially in a person who is disabled enough to stop working and is the primary caregiver of a wife with dementia. The lack of appropriate investigation in a timely manner is, from my perspective, linked to a dysfunctional health care system and also to promoted behavioral changes that may be inferred from the statement referred to above. I assume it was not the intent to discourage physicians from ordering tests or to inadvertently justify administrative decisions within a dysfunctional health care system, but I also think awareness of the potential unintended consequences of using platforms and words should be carefully considered.

Why would it be reasonable to assume that a physician ordered an investigation solely to satisfy their curiosity, and why would anyone presume that the evidence did not support its use? I think that a better recommendation might be "For the sake of responsible stewardship and in alignment with evidence-based care, medical decisions should include consideration of the entire clinical context and all competing interests."

—Scott A. Lang, MD, FRCPC, FANZCA (retired)
Calgary, Alberta

Re: Switching to permanent daylight saving time

I agree with Drs Schwandt's and Khorasani's editorials about the limitations of the transition to permanent daylight saving time in BC [*BCMJ* 2026;68:122; 2026;68:156-157,159]. Additionally, permanent daylight saving time is a contradiction, as daylight saving time is defined as moving clocks forward by 1 hour in the spring, then "falling back" as winter approaches. The reality is that BC has moved from Pacific Time (either Standard or Daylight) to Mountain Standard Time, defined as Coordinated Universal Time (UTC) – 7 hours. Mountain Time centres on a longitude of 105° W, passing near Regina, Saskatchewan. BC now uses the same clock as Arizona (which does not have daylight saving time). Alberta will switch to permanent Central Standard Time (UTC – 6 hours) so will remain 1 hour ahead. Premier Eby wants to rename

BC Mountain Time as "Pacific Time," but he is wrong: Pacific Standard Time remains UTC – 8 hours.

As Vancouver and Victoria are both farther west than 120° W longitude (corresponding to 8 hours west of the Greenwich meridian), to match geographic time to our circadian rhythm in the most populated areas of BC, we should move our clocks back—or perhaps just adopt permanent Pacific Standard Time, rather than permanent Mountain Standard Time. With the transition made, Dr Khorasani correctly notes that sunrise will be at 9 a.m. in the middle of winter in Victoria and Vancouver. As the BC coastline continues even farther west, going north, by December the sun will rise at around 10 a.m. in Prince Rupert, Stewart, and Haida Gwaii, but at 8 a.m. in Hyder, Alaska.

The time change will be a major disincentive for anyone who needs to get out of bed to go to work or school. And a sunset 1 hour later during the winter is unlikely to promote outdoor evening recreational activities, as it will be dark. I predict that this "experiment" will fail.

—Richard S. Taylor, MB BS, FRCPC
Victoria

Re: Stethoscope technology and use

In his letter about chest auscultation [*BCMJ* 2026;68:159], Dr Murray Trusler poses two questions: Why are doctors not applying stethoscopes to bare skin, and why are they not using electronic stethoscopes?

René-Théophile-Hyacinthe Laennec is said to have placed his ear directly to the bare chest of his patients. Then he transitioned to a tube of rolled paper for the sake of modesty, particularly with female patients (others say he did it to avoid the fleas).

While I occasionally experienced the latter when examining patients, perhaps modesty, medicolegal concerns, speed, and laziness are to be considered as the reasons for the current practice of auscultation through clothing.

As regards electronic stethoscopes, the cost (close to $2000 for some models) is undoubtedly a major prohibiting factor for medical students. That is when most of us make the investment in our first instrument, which we then continue with into office practice.

But Dr Trusler is correct that we seniors need all the help we can get when auscultating. As an intern in 1966, I recall eagerly presenting my findings of a faint diastolic murmur to the patient's older attending physician. When I asked for his opinion about it, he replied, "I tell you, Walter . . . I don't hear so good."

—Anthony Walter, MB BCh
Coldstream

Where do fee codes come from?

For many members of Doctors of BC, checking the box to join their section and society may seem like an unnecessary expense. What is a section's primary role,

anyway? What is the role of the two major societies—BC Family Doctors (previously the Section of General Practice) and Consultant Specialists of BC?

Like many things in life, it helps to follow the money trail. The first and foremost duty for sections is to manage their respective fee codes—amending existing codes and creating new ones. Just like conceiving a baby, the birth of a fee code takes two partners—the section and the Ministry of Health. It starts with a section recognizing when a new fee code is necessary to provide optimal patient care and ensure that its members are remunerated fairly. To fund a new fee code, the section must use money from its own budget, as allocated by the Physician Main Agreement. The section writes a proposal for review by the Ministry of Health. The ministry compares the proposed new fee code to existing fee codes and possibly to fee codes in other provinces and confirms the anticipated cost and use of the code. There is an active dialogue with the section about any issues the ministry foresees. Finally, the fee code is presented to the Doctors of BC Tariff Committee for review, and final approval is provided by the Medical Services Commission.

As you can imagine, coming up with a fee code, writing a proposal, interacting with the Ministry of Health, and possibly presenting to the Tariff Committee consumes time and, for most sections, is unpaid work done off the side of someone's desk. This process is not static. Fee codes must be updated periodically to reflect shifts in practice patterns and to update and modernize language. A large section like BC Family Doctors has staff support and contracted physicians with expertise to complete this crucial work. Consultant Specialists of BC has a single physician undertaking this work. For small sections with only a few executive members, there is no budget for physician stipends or staff. This leaves them isolated doing this work unpaid while putting them at a disadvantage to modernize fee codes and apply for new ones. Membership is a critical means of supporting this work, but more needs to be done.

Even though every couple is unique, the process of having a baby is the same. Similarly, each section and its fee code needs are unique, but the process to create or alter a fee code is similar. Having support to ensure that all physicians in BC have access to adequate economic assistance is essential. This is why BC Family Doctors and Consultant Specialists of BC are advocating for equitable economic support for all BC physicians undertaking Physician Main Agreement–related work, including section leaders.

Please consider becoming a member of your respective group today to support this important work and strengthen the voice of physicians across BC. ■

—Tahmeena Ali, MD
Chair, BC Family Doctors

—Robert Carruthers, MD
President, Consultant Specialists of BC