What Doctors of BC does for me

As a student on a budget, I love the word *free*, so I took an inventory of what's free out there for medical students. I knew that my Doctors of BC membership is free during my 4 years of medical school, but I had forgotten that this includes a free CMA membership, which means free access to handy resources such as RxTx and DynaMed Plus, not to mention various additional deals and discounts.

I knew that I received free life insurance with Doctors of BC through my 4 years of medical school as well, but as of the 2018–19 school year Doctors of BC disability insurance is also free through all 4 years. That's saving me at least $925 in premiums!

I knew about the rural-rotation travel stipend of up to $800, but I almost forgot about the $250 weekly housing allowance for up to 8 weeks: all the more reason to do a rural elective in fourth year.

I knew that Doctors of BC provides some of the needs-based bursaries applied through the UBC Student Service Centre (up to $250 000 is donated each year), but I was not aware of other ways to win money. I could win a $1000 prize for submitting an article to the *BCMJ*, a $250 prize for writing a *BCMJ* blog post, a $5000 award for demonstrating interest in rural medicine, and a $1000 Changemaker Award for demonstrating leadership in advocacy.

Of course, Doctors of BC hosts the much-anticipated annual Backpack Day for first-year students, but this year I attended the other big (and arguably more important) annual event—Find Your Match, where I and other students got insider tips from physicians from various disciplines while enjoying a scrumptious, fully catered meal.

Free membership plus all those extras—that's a lot of value.

—Jessie Wang
Medical Student Intern,
Doctors of BC

Changes to GPSC fees

The GPSC has made changes to some of its fees to enable delegation, simplify billing, and clarify requirements. These changes are part of the GPSC's continued efforts to support full-service family doctors to improve access to care and services.

Enabling delegation

As part of the service requirements for the GPSC planning fees, doctors may now delegate non-face-to-face planning tasks to College-certified allied care providers working in a GP practice. This change affects the following four GPSC incentives:

- G14033: GP Complex Care Planning and Management Fee
- G14043: GP Mental Health Planning Fee
- G14063: GP Palliative Care Planning Fee
- G14075: GP Frailty Complex Care Planning and Management Fee

Simplifying billing

The Personal Health Risk Assessment (Prevention) (G14066) has been amended to align with the GPSC planning fees. Physicians are no longer required to bill a visit fee in addition to the G14066 fee. A visit fee may still be billed in addition if medically required and does not take place concurrently with the face-to-face planning included under G14066. This change is effective 1 January 2019.

Clarifying documentation

To reflect a recent change to MSP's counseling fee 0120, the GPSC added the following note to some of its mental health fees: "Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required." This note has been added to the following five GPSC fees:

- G14044: GP Mental Health Management Fee age 2–49
- G14045: GP Mental Health Management Fee age 50–59
- G14046: GP Mental Health Management Fee age 60–69
- G14047: GP Mental Health Management Fee age 70–79
- G14048: GP Mental Health Management Fee age 80+

It is recommended that GPs ensure that clinical notes for any 0120 or GPSC mental health management fee billing include the required documentation as of 1 December 2018.

For details on all of these changes, including links to updated GPSC billing guides, visit www.gpscbc.ca.

News continued on page 88

Continued from page 65

Some pregnant women don't believe cannabis is harmful to their fetus

Up to one-third of pregnant women do not believe cannabis is harmful to their fetus, according to a review by University of British Columbia researchers. In some cases, women perceived a lack of communication from their health care providers about the risks of cannabis as an indication that the drug is safe to use during pregnancy.

The findings are outlined in a new review, published in *Preventive Medicine*, in which UBC researchers sought to identify the latest evidence on women's perspectives on the health aspects of cannabis use during pregnancy and postpartum, and whether their perceptions influence decision making about using the drug. The research suggests that, over the past decade, more women seem to be using cannabis during pregnancy, even though evidence of its safety is limited and conflicting. For the review, researchers identified six studies conducted in the United States that looked at women's perceptions about cannabis use during pregnancy. Across the studies, the rate of cannabis use among pregnant women varied considerably. In a large US population-based study, nearly 4% of women self-reported using cannabis within the past month, while 7% self-reported using cannabis within the past year. In another study that saw researchers also test hair and urine samples, the rate of cannabis use increased to 28%.

Pregnant cannabis users were more likely to be under age 25, unemployed, single or uninsured, African-American, and to have low income and education, or use other substances such as tobacco and alcohol. A diagnosis of anxiety or depression was also associated with cannabis use during pregnancy. Researchers found that cannabis use rates were highest during the first trimester (7.4%) and lowest during the third trimester (1.8%). Most pregnant users reported using cannabis to treat nausea early in their pregnancy. In one study involving 306 pregnant women, 35% reported being cannabis users when they realized they were pregnant. Two-thirds of those women quit after finding out they were pregnant, but among those who continued to use cannabis, half reported using almost daily or twice a week. When women were asked about their perception of general harm associated with cannabis use, 70% of both pregnant and nonpregnant cannabis users responded that they perceived slight or no risk of harm. In another study, when asked if they believed cannabis is harmful to a baby during pregnancy, 30% of pregnant women responded "no." When women were asked to identify substances most likely to harm the baby during pregnancy, 70% chose alcohol, 16% chose tobacco, and 2% chose cannabis (see **Figure**).

While research on the health effects of cannabis is limited, some studies have shown an increased risk of problems for pregnant women, including anemia, low birth weight, stillbirth, and newborn admission to the neonatal intensive care unit. Due to the risk of potential problems, many professional organizations, including the Society of Obstetricians and Gynaecologists of Canada, recommend women not use cannabis when trying to conceive, during pregnancy, and while breastfeeding. Still, some women reported that not having specific counseling provided about the risks of cannabis use suggests that the drug is safe. One finding revealed that some people don't consider cannabis to be a drug, making it especially important for health care providers to ask specific questions about cannabis use during pregnancy and breastfeeding.

Lead author, Hamideh Bayrampour, is an assistant professor in the UBC Department of Family Practice and an affiliate investigator at BC Children's Hospital Research Institute. The review article, "Women's perspectives about cannabis use during pregnancy and the postpartum period: An integrative review," is available online at www.sciencedirect.com/science/article/pii/S0091743518303773?via%3Dihub (login required).

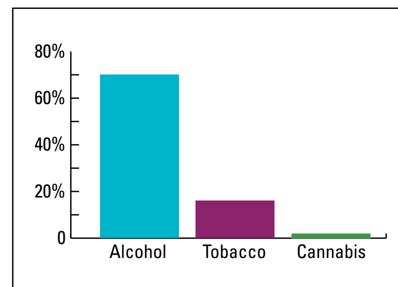


Figure. Pregnant women's perception of substances most likely to harm the baby during pregnancy.

Preventing overdose deaths among people recently released from a correctional facility

A new project aimed at supporting people transitioning back to their communities when they are released from a correctional facility could prevent overdoses and help clients get on a healthier path.

Roughly two-thirds of British Columbians who died of an illegal drug overdose between 1 January 2016 and 31 July 2017 had recent contact with the criminal justice system, according to a death review panel report[1] released by the BC Coroners Service in 2018. Of those, 10% (333 people) died within their first month of release from a correctional facility.

Five new community transition teams stationed throughout BC aim to address this problem by helping people with opioid-use disorders access treatment in their communities after release from a corrections facility.

The teams are currently stationed in Surrey, Prince George, Kamloops, Nanaimo, and Port Coquitlam. Each consists of a social worker and a peer—a person with lived experience

with drugs, the correctional system, or both. The teams will work with clients for approximately 30 days following their release to connect with a community physician, fill prescriptions, and access other recovery supports.

Recently incarcerated clients at greater risk of overdose

Dr Nader Sharifi, medical director for Correctional Health Services and addictions lead for BC Mental Health and Substance Use Services, reports that currently about 40% of people in corrections facilities receive opioid agonist treatment, which includes medications such as Suboxone and methadone to treat opioid use disorder. He says people are at heightened risk when they leave corrections and no longer have access to the facility's physician. Additional risk factors include lowered tolerance and the trauma associated with release.

Role of peers in recovery is vital

Andrew MacFarlane, provincial executive director for Correctional Health Services, has spent 20 years working with people with mental health and substance use issues, and the last 5 working with people on Vancouver's Downtown Eastside. MacFarlane and his team designed the community transition team project after consulting with regional health authorities

Continued on page 90

A model of global health engagement

The Canada India Network Society was established in 2010 to connect leaders from Canada and India in order to build collaborative opportunities among the countries' academic institutions and industries. The Canada India Network Initiative 2018 was the society's third conference. Though focused on a subset of the South Asian population, the conference vision was global engagement and building links between people through health care.

The conference started with welcome remarks from the Honourable Adrian Dix, Minister of Health, and Dr Arun Garg, the conference chair. Sessions included:

- War on Diabetes. Deljit Bains, leader at the South Asian Health Institute, advocated for transformation in the community in health promotion through direct engagement at places like gurudwaras and temples. Dr Gulzar Cheema shared his work on the interCultural Online Health Network, a community-driven health-promotion initiative that supports multicultural communities, patients, and caregivers across BC to optimize chronic disease prevention and self-management. Sean McKelvey shared his work in making diabetes care drug-free. The final speaker, Dr JST Thakur of India, addressed the approaching tsunami of diabetes.
- Mental Illness. Dr Nitasha Puri spoke about the need for immediate action in the prevention and cure of addictions in the context of her work with Fraser Health's Roshni Clinic. Dr Suman Kollipara focused on alternative and integrated approaches like meditation and self-empowerment tools for prevention of mental illness.
- Public Health Approaches to Palliative Care in India and BC, looking at the work done by the Two Worlds Cancer Collaboration, was presented by Drs Doris Barwich and Gillian Fyles and facilitated by Dr Simon Sutcliffe.
- Leadership in Health. Drs Arvind Lal, Anupam Sibal, and Robert Woollard brought decades of experience to shed light on the need for better practices in health care.
- Empowering Physicians. This session was presented using the LEADS framework, including principles of leading self, engaging others, achieving results, developing coalitions, and transforming systems.
- Integrative Medicine and Health. Medical professionals, research scientists, traditional Chinese medicine practitioners, and yoga practitioners reflected on their personal journeys as well as their patients' journeys. Presentations covered the importance of integrative medicine in the prevention of dementia, supportive cancer care, food as medicine, traditional Chinese medicine, Indigenous medicine, and integrated yoga therapy. The overall message was that chronic disease requires an integrative approach to care.
- Technology and Innovation. Discussions centred on artificial intelligence in health care, taking action against tuberculosis, the role of technology in access to health information, mobile technologies, and using neuroethology in youth depression and addiction. Kathy Kinloch, BCIT President, and the Honourable Bruce Ralston, Minister of Jobs, Trade and Technology, were featured speakers.
- Two roundtable discussions on technology and integrative medicine focused on identifying research opportunities between India and Canada—building bridges between modern innovation and ancient technologies.

For more information about the conference and the organization, visit www.thecins.org.

—Arun K. Garg, MD
—Reza Alaghehbandan, MD
—Suman Kollipara, MD

Continued from page 89

and the First Nations Health Authority, and analyzing other evidence-based models across Canada.

The community transition team peers have been chosen strategically—they work with community organizations throughout the province that will keep helping clients after the short-term work with community transition teams concludes. The teams began connecting with their first clients in January. The Provincial Health Services Authority hopes to scale the project up next year based on results. A short video about the community transition teams is available at https://youtu.be/JuUqCPOlJvs.

Reference

1. BC Coroners Service death review panel: A review of illicit drug overdoses. 5 April 2018. Accessed 31 January 2019. www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/bccs_illicit_drug_overdose_drp_report.pdf.

UBC research examines living well while dying

A University of British Columbia professor in the Faculty of Health and Social Development, School of Nursing, Kelowna, has determined that people diagnosed with terminal cancer—who have hope, positivity, and family support—are able to live well during the advanced stage of the disease.

Carole Robinson, professor emeritus with the UBC Okanagan School of Nursing, recently published a paper with co-authors explaining the process of living well with an awareness of dying. Robinson notes that globally there are 14.1 million new cancer cases diagnosed each year, 8.2 million cancer deaths, and 32.6 million people living with cancer. Historically, researchers have studied the concept of living well with a chronic illness, but not specifically cancer. Robinson says those studies convey the idea it may be possible to live well with advanced cancer, but little is known about how it is done or how to support it.

The study analyzed 22 interviews with Spanish adults involved in previous research that explored their experience of living with advanced cancer. The researchers found the participants engaged in a five-phase iterative process: struggling, accepting, living with advanced cancer, sharing the illness experience, and reconstructing life. This process revolved around participants' awareness of dying, which differed from people living with chronic illness, and was a unique aspect of this new research.

Each phase was revisited and, as the disease advanced, living well got more challenging. Participants talked about strategies for living with advanced cancer, including making life adjustments, maintaining a positive attitude, normalizing, and hoping.

Over time, participants realized struggling against the disease created additional difficulties. They understood it was counterproductive so they made a conscious choice to let go of struggling. Some referred to it as being the only choice they could make while living with the uncertainty of advanced cancer. This enabled accepting their life circumstances at some level and learning to live alongside their illness.

Robinson says that the importance of family love and support cannot be underestimated. For all the participants, she adds, awareness of dying led them to focus on living well. Sharing the experience with loved ones softened suffering remarkably. They were aware they did not have time to lose. Robinson says the key takeaways to living well encompass a balance between dependence and independence, being able to see the positive, and maintaining hope even in the end stages of the disease.

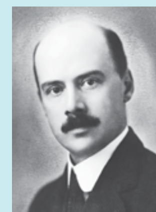
The study, "People with advanced cancer: The process of living well with awareness of dying," was published in *Qualitative Health Research*. It is available online at https://journals.sagepub.com/doi/10.1177/1049732318816298.

STUDENTS:

Cash prizes for writing

J.H. MacDermot Writing Award

The *BCMJ* invites writing submissions from student authors, and each year awards a prize of $1000 for the best medical student submission accepted for print and online publication. Students are encouraged to submit full-length scientific articles and essay pieces for consideration.



The J.H. MacDermot Writing Award, sponsored by Doctors of BC, honors John Henry MacDermot, who served as editor for 34 years (1932–1968), overseeing the publication's transition from the Vancouver Medical Association Bulletin to the *BCMJ* in 1959. Dr MacDermot also served as BCMA president in 1926.

BCMJ Blog Writing Prize

To encourage med students to take their first foray into medical writing, the *BCMJ* awards an additional writing prize of $250 twice per year for the best 200- to 400-word blog submission accepted for online publication.

For submission guidelines and contest deadlines, please visit www.bcmj.org/submit-article-award.