Letters of less than 300 words are welcomed provided they do not contain material that has been submitted or published elsewhere; they may be edited for clarity and length. Letters may be e-mailed to journal@doctorsofbc.ca, submitted online at bcmj.org/content/contribute, or sent through the post and must include your mailing address, telephone number, and e-mail address.

Advertisement for Doctors of Optometry in *BCMJ*

It has been brought to our attention that the *BCMJ* recently included advertising for Doctors of Optometry with a full-page ad and a rolling advertisement bar on the online version.

There is great confusion among the public about the words *ophthalmologist* and *optometrist*, with no understanding that an ophthalmologist is a physician and an optometrist is not. The use of the title *Dr* by optometrists reinforces the confusion, and the new advertising campaign by the profession of optometry using the byline "doctor-delivered" is consolidating the blurring of the significant difference.

We are very concerned that optometrists are presenting themselves now not only to the public but to general practitioners and family physicians as the primary providers of "doctor-delivered" eye care.

We point out that all the eye health services provided by optometrists are provided by ophthalmologists and at no charge to the patient. Precisely because optometrists are not physicians, they are self-regulating, self-governing, and do not fall under the Canada Health Act. This allows them to extra bill the patient over and above MSP payments for all services provided.

Patient confusion and any potential physician confusion about whether optometrists are physicians and provide the same level of health service as ophthalmologists are not in the best interests of patients. We note in your mission statement the focus on physicians, being "by BC physicians, for BC physicians."

Optometrists are not physicians. Do you accept advertising from naturopaths, midwives, and other allied health professionals?

We wish to express our deep concern that this type of advertising is not appropriate for a journal that presents itself as distinctly medical and by and for physicians to include advertising from a nonphysician group presenting themselves as doctors without explanation that they are not physicians, do not have physician training and experience, are not governed by the Canada Health Act, and extra bill patients as a matter of course.

—D.S. Dhanda, MD, FRCSC
President, BC Society of Eye Physicians and Surgeons

Potential advertisements for the BCMJ *are evaluated on an individual basis, and the revenue generated from advertisements is used to reduce the cost of the journal to Doctors of BC members. We were confident that family physicians are aware of the difference between optometrists and ophthalmologists and didn't realize that the ad in question would be upsetting to ophthalmologists. We apologize for any hard feelings this may have caused.* —Ed

Re: Electronic wound monitoring

I read with interest Dr Hwang's study on electronic wound monitoring after ambulatory breast cancer surgery [*BCMJ* 2016;58(8):448-453]. I do not believe reported results support his conclusions.

It was concluded the app improved the patient experience, but the retrospective control group was not surveyed so no relative conclusions on patient experience are possible. Also concluded was that fewer unscheduled visits were necessary, but three unscheduled follow-up visits in the app group were not counted. Two patients required unscheduled e-visits and one an office visit. These visits were not scheduled when the patients left hospital and inclusion invalidates the hypothesis the app reduced unscheduled visits. I question whether unplanned visits without complication is a meaningful endpoint given that one group was provided an alternate avenue for care (the app). It seems like providing smart phones to half a population and considering unplanned pay phone use a treatment failure.

I would also be interested in how much time was required to create and respond to pictures with text (140 in total if all 35 patients complied with four messages) and consider whether that is a cost benefit as opposed to extra ED (four) and walk-in visits (two).

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Regarding conclusions that were not made but can be observed, it seems the study populations are different, with the conventional group being older, with more complex surgery (longer operative times) and more advanced disease (zero DCIS vs seven in the app group). I don't think we can meaningfully compare non-wound complication rates, since remote unreported complications would not be detected on the app (pressure sores or bradycardia for instance) but might be in person or by synchronous visit. Perhaps most concerning is that there were 3 wound complications in the conventional group (1 leaking drain and 2 infections) vs 11 in the app group (6 infections, 2 minor hematomas, 1 each of edge necrosis, hemorrhage, and pneumonia). The Yates *P* value (3+34/37 vs 11+24/35) is almost significant at .055%. This may be due to overtreatment of possible infection in the app group but should be considered in future study design.

I do appreciate the considerable time and effort the study must have taken and applaud Dr Hwang as clinical pioneer in this promising BYOD e-health initiative. I have used Medeo and think it's a great platform, though I don't think this study proves its value in this use case. I also considered it awkward that a published peer-reviewed study should include so many pictures and references to a commercial product, particularly when the issue includes a full-page paid ad.

—Mike Figurski, MD
Kelowna

That a QHR Technologies ad (Medeo being one of the products advertised) ran in the same issue as Dr Hwang's article was entirely coincidental. Dr Hwang had no knowledge that such an ad would run, and indeed these ads have been running in every issue since September. The BCMJ *does not object to the mention of commercial products in articles if the reference is relevant and helpful to readers, as it was in this case.* —Ed

The author replies

I appreciate the opportunity to respond to the letter submitted by Dr Figurski.

I believe that the lack of a control group for patient satisfaction, lack of randomization, and differences between the study and control group were adequately addressed under "Study limitations" published in the paper.

In three cases, I scheduled additional appointments as clinically required. I did not consider these appointments, two electronic and one in person, as "unscheduled care." For the study purposes, I only considered visits to the emergency department or walk-in initiated by the patient without my knowledge as "unscheduled."

Responding to a patient using the Medeo platform on my iPhone took approximately 2 minutes per instance, including billing the MSP fee code 10006 (Specialist Email Patient Management/Follow-Up) using a separate Accuro iPhone app.

This research was conducted without any funding from any source. Transparency and academic integrity is very important to me in terms of conflict of interest. I felt so strongly on this point that, on my own accord, I sold all of my shares in QHR before this paper was accepted for publication by the *BCMJ*. The *BCMJ* has a conflict-of-interest declaration process for peer-reviewed papers. It is noteworthy that *subsequent* to acceptance of the paper, QHR was acquired by Loblaw on 22 August 2016 with a significant increase in the QHR share price. I can confidently declare that I currently have no financial interest in QHR or its subsidiaries. I am, however, an unapologetically enthusiastic user of QHR's products, Accuro and Medeo, and a proponent for the use of novel technology to improve patient

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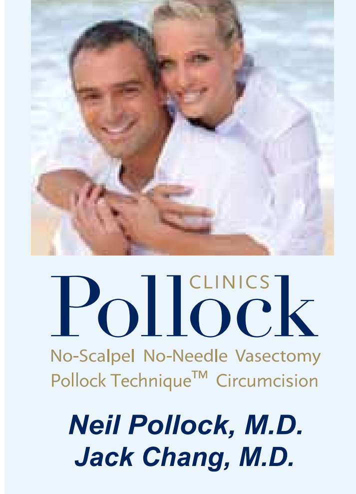

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care. As I concluded in the paper, I hope my research can be used to help develop a more rigorous, multicentre, randomized controlled study by institutions that have the resources to conduct this kind of research. The Vernon Jubilee Hospital does not fall into this category.

—Hamish Hwang, MD, FRCSC, FACS

The BC opioid crisis

My area of interest in the treatment of chronic noncancer pain and the treatment of addiction to opioids over the past 17 years has afforded me some unique perspectives on the BC opioid crisis that I would like to share.

Addiction is a behavioral diagnosis that is made over time when it becomes obvious that a person is unable to control compulsive behaviors with negative consequences associated with the misuse of a substance or behavior (e.g., substance: heroin; behaviour: gambling).Taking opioids does not cause the addiction. To be clear: Taking prescription opioids does not cause the addiction. Addiction is behavioral. Not all patients prescribed opioids will exhibit addictive behavior. However, addicts prescribed opioids will get into trouble.

Taking a course of opioids may certainly cause a physical dependence that is manifested by withdrawal. This is something any mammal will exhibit. It's a physiological response to the prolonged exposure of the body to opioids. Addicts in withdrawal are merely exhibiting what all of us would experience if we were similarly exposed to opioids for a period and had them withdrawn. Being in withdrawal does not make one an addict.

Most physicians are not trained to identify the behavior of addiction or how to respond to it. The College has a duty to address this deficiency in training in all physicians who are permitted to prescribe opioids. The BC government has an obligation to fund this so that something at a grassroots level can be done about this crisis. Identifying aberrant behavior and knowing how to respond to it requires training. Are the College and government of BC listening? This is their responsibility.

In order to identify high-risk patients prior to deciding if an opioid should be prescribed, sufficient time is required to do an in-depth assessment of these complex chronic pain patients. Until there is a fee code with remuneration that adequately reflects the time and effort needed to do this properly the cursory assessments of chronic pain patients will continue to be done and the resultant poor prescribing practices will remain.

Lower-risk opioids such as tramadol, the buprenorphine patch, or tapentadol are not covered by the province. This is another reason for the crisis we are having. Having worked in Australia recently as a locum family physician where far fewer opioid prescriptions are written, I soon realized why there is a problem in BC. Tramadol and the buprenorphine patch are covered in Australia, and these safer opioids were the first-line medications that I used to treat patients with chronic pain. When physicians have safer opioid alternatives to prescribe there are far fewer problems. This is something the government of BC is responsible for. If they are to act and do something concrete to quickly and safely change the opioid landscape this is where they need to be focused. This would greatly assist the opioid prescribers. I know this because I have experienced it firsthand.

I believe that the physicians, the College, and the BC government will all have to work together to tackle this problem. It all starts with responsibility being taken so that those with the power to implement change may be guided to do so. This requires leadership from knowledgeable physicians of which there are quite a number in BC and who are very willing to engage. Will the College, in concert with the government, approach them for guidance?

—Paul Harris, BSc, MBBCh, LMCC, CCFP
Duncan

The College replies

The College appreciates the opportunity to respond to Dr Paul Harris's letter to the Editorial Board of the *BCMJ*. We applaud Dr Harris for championing the need to adequately compensate physicians for the time needed to comprehensively assess complex patients who have difficult diagnoses such as chronic pain and/or addiction. We agree that addiction is a diagnosis that is made over time, and is not synonymous with tolerance. The cardinal signs of loss of control, compulsion, and continued use, despite negative consequences, must be present to make a diagnosis of addiction. This clinical diagnosis can often only be made with longitudinal exposure to the patient, and underscores the importance of being highly selective generally, and vigilant to that risk over time, especially when prescribing opioids for chronic conditions.

It is true that many physicians are not trained specifically in addiction medicine and may not know how to respond when confronted with it. For this reason the College has developed a number of workshops on both addiction and pain management, including a specialized course on safe prescribing that utilizes role playing and patient-simulated scenarios to help physicians in this difficult type of practice. Additionally, the College engages medical consultants with experience in treating patients with complex chronic pain and addiction conditions to assist registrants with this complex patient population. Each year the College interacts with over 200 physicians who have been identified as needing additional training and resources to prescribe safely. The

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College was also an active contributor to the curriculum development process for the Practice Support Program (PSP) Pain Management Module. The College has been highly supportive of practitioners.

Fee guide matters are not within the purview of the regulatory authority. That is entirely the responsibility of Doctors of BC, the advocate for the profession. We encourage Dr Harris to continue his quest to achieve appropriate remuneration for his work, as well as sensible formularies for patients with chronic conditions. Meanwhile, the College will do what it has done for the last 2 decades: use the provincial database (PharmaNet) to identify physicians who may benefit from further training, particularly in the areas of addiction and chronic pain.

More information on the College's workshops and courses is available in the Professional Development section of the College website at www.cpsbc.ca.

—Gerrard A. Vaughan, MD
President, College of Physicians and Surgeons of British Columbia
—Heidi M. Oetter, MD
Registrar and CEO, College of Physicians and Surgeons of British Columbia

Re: Opioid prescribing

On behalf of the College, I applaud Dr Alan Ruddiman for his courage and leadership in expressing his personal view on the current opioid crisis in his thoughtful piece, "Opioid prescribing: The profession and the patients we serve and support" [*BCMJ* 2016;58:439,441].

While virtually all physicians yearn to be better prescribers of opioids and other potentially addictive medications, we have sadly seen far too many cases like "Jack's," as described by Dr Ruddiman. Prescribing by some physicians has undoubtedly played a part in the current crisis, and as such, the College echoes his call for physicians to collectively help address it.

One of the most common challenges for physicians, as identified in Dr Ruddiman's piece, is not knowing what to say to patients who are clearly suffering from pain but who are also vulnerable to potential harms from long-term opioid use. Physicians have an appetite for and are highly receptive to scripts, which they can acquire by calling the College or attending CME activities such as the College Prescribers Course, the Foundation for Medical Excellence Chronic Pain Management Conference (register for both on the College website), or the PSP Chronic Pain Module. Ultimately, patients are owed the information they need to make safe and appropriate choices. That cannot be accomplished without speaking frankly.

Physicians should never forget that they are professionally responsible for the prescription that they provide—both to the patient and public. The standard *Safe Prescribing of Drugs with Potential for Misuse/Diversion* is written with enough flexibility for physicians to make professional judgments that are in the best interests of individual patients. We thank Dr Ruddiman for his leadership in recognizing that the profession has an obligation to prescribe safely.

—Gerrard A. Vaughan, MD
President
College of Physicians and Surgeons of British Columbia

The president replies

I wish to state that the President's Comment I wrote for the October *BCMJ* [2016;58:439,441] on the topic of opioid prescribing was singularly my perspective, as a practising generalist physician and active member of the profession, not necessarily the official position of Doctors of BC. Presidents who serve the association are given this forum to communicate with members—that is the nature of

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the President's Comment. I had hoped my comments would encourage a robust discussion among members, which is now taking place. Our members' views will be considered when this topic is fully discussed with the Board of Directors to determine your association's official position now and in the future.

—Alan Ruddiman, MBBCh, Dip PEMP, FRRMS
Doctors of BC President

Re: Orphaned patients

I completely agree with this insightful editorial ["Ah, the good ol' days. Nary an orphan in sight." *BCMJ* 2016:58(5):244]. Why are there orphans now when there were none in the past? UBC Medicine graduated approximately 50 doctors in the early to mid-1960s compared to close to 300 currently. That's 5 to 6 times as many for a population that has increased only about 2.6 times, and the number of doctors in the province then (no orphans) was 1 for every 800 in the population, and now (a lot of orphans—200 000 with no FPs) is 1 for fewer than every 400. Doctors literally fought over patients in the past—some, so I'm told, were armed! Heads of clinics in the Interior met uninvited incoming GPs at the rail station and told them to move on.

I agree that the solution is not clear, but the causes are, and it starts with the discontinuation of the rotating internship as was pointed out by an editorial in the *Canadian Journal of Plastic Surgery* some years ago. The outcome of a rotating internship was that 100%—everyone—was licensable to practise as a GP, which many did, most of whom would go into practice with a group or clinic and have hospital privileges (that being requirement to practise). Some would then go on to a specialty being better informed; many would stay as very competent GPs. Contrary to what the universities think, the experience of a neophyte GP in these circumstances was hugely educational, and the mentoring received by being in contact with many varied doctors was immense. Not formally a team, but it absolutely was.

This is in stark contrast to recent reports that 52% of graduates are now choosing general/family practice, clearly not something to be proud of.

The other causes, which include doctors and nurses no longer running the hospitals; the hostile environment of hospitals to GPs-FPs, as was pointed out by a previous president of Doctors of BC; administrators being not well-informed administrators and often, it seems, functioning for their own benefit, have contributed hugely to this current, hugely unfortunate, and clearly avoidable situation.

—Michael M. O'Brien, MD, FRCPC
Langley

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