BCMJ BC Medical Journal

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.

Re: Management of influenza with Tamiflu

Reading the article on the use of oseltamivir (Tamiflu) for treatment of influenza [*BCMJ* 2015;57:402-406] was like revisiting an old nightmare. Worldwide, governments have invested over $9 billion in stockpiling this most controversial drug. The Canadian government spent about $400 million several years ago only to have the stockpile outdate before it was used. Multiple studies attest to the very marginal benefits of this expensive drug.

The article conveniently failed to rationally address the concept of cost-benefit ratio with regard to the use of the drug. Thousands of primary care practitioners have long ago decided the efficacy (or lack thereof) regarding this drug. That is why it is not widely used, as the article points out. Public health dollars could be spent more effectively on other endeavors in my opinion.

—Robert H. Brown, MD
Sidney

Authors reply

We thank Dr Brown for his interest in our article, "Management of influenza infection in children and pregnant women in BC, an update."[1] His comment raises important distinctions between the use of oseltamivir for severe influenza infection versus issues related to more permissive treatment and policies related to drug stockpiling. Dr Brown's concerns about government stockpiling of oseltamivir are valid, and we agree that there is a great deal of controversy around these decisions.[2-4] Although several studies have reported that oseltamivir is cost effective for the treatment of influenza in most scenarios,[5-9] cost effectiveness and policy decisions regarding the stockpiling of oseltamivir are outside the scope of our article.

Our article provides practical local guidance for the diagnosis and treatment of influenza in children and pregnant women.[1] As described in the article, we agree that the absolute clinical benefit of oseltamivir for treatment of mild influenza infection in healthy outpatients with influenza is small, based on several randomized controlled trials.[10,11] Unfortunately, placebo-controlled, randomized treatment studies of severe influenza are not available and are unlikely to be performed. Nevertheless, a large number of well-conducted observational studies indicate that oseltamivir has substantial benefits for severe influenza, including improved survival.[12-15]

Our algorithm recommends testing or treating only those patients who are hospitalized for respiratory illness, who have risk factors for severe influenza disease, or both. These evidence-based recommendations are slightly more restrictive than—but otherwise consistent with—those of expert pediatric and infectious disease committees in North America (Canadian Paediatric Society, Association of Medical Microbiology and Infectious Disease Canada, American Academy of Pediatrics, Infectious Diseases Society of America, Centers for Disease Control and Prevention) as well as in the UK, Europe, and Australia.[9,16-19] We hope that more effective antivirals become available but, in the meantime, we continue to recommend oseltamivir for selected patients as the best available treatment for influenza.

—Ashley Roberts, MD, FRCPC
—Soren Gantt, MD, PhD, FRCPC
—Karen Ng, BScPharm, PharmD, BCPS
—Vanessa Paquette, BScPharm, PharmD
—Kristopher Kang, MD

References

Available at bcmj.org.

Re: November 2015 cover image

I was very disappointed to see the *BCMJ* adopting a caduceus car key fob on the cover of the November 2015 issue. Using the caduceus as a symbol of medicine is a very common American solecism that I had hoped would be less seen in Canada. The caduceus is the winged staff with two entwined snakes that is associated with Hermes, the messenger of the gods (and also Mercury). It is also the ancient astrological symbol of commerce (which many might cynically think is very appropriate as a symbol

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of North American medicine!). The true symbol of medicine is the staff or rod of Aesculapius (Asclepius)—a rod with a single entwined snake and no wings. It is, of course, on the badge of the Royal Army Medical Corps and the Canadian Army Medical Corps.

—Victor Black, MD
Vancouver

Re: Wait times for general surgery in BC

Thank you to Drs Chan, Hwang, and Karimuddin for a well-researched article on the state of wait lists in BC [*BCMJ* 2015;57:341-348]. However, the data from the Surgical Patient Registry (SPR) are inaccurate because changes relating to patients waiting for surgery are not entered into the system. As a result, the Ministry of Health requires health authorities to audit wait lists, and 10% to 20% of patients are regularly removed through this process. In addition, the data on the percentage of patients receiving treatment within the designated timeframe for their diagnosis also lack accuracy: the use of the prioritization codes was inconsistent immediately after implementation.

The solution to this problem is to have up-to date, synchronized information about patients waiting for surgery. This will require a new electronic system to connect the GP's and surgeon's EMR with the hospital electronic record and the SPR. This information would be used to schedule patients and monitor their performance. It would also be used to analyze wait lists to define backlogs and growth in demand.

A proposal for such an electronic system has been submitted to the Ministry of Health by the Provincial Surgical Executive Committee. The intention is for seamless integration with physician EMRs and hospital systems. In addition, the proposal includes a portal for patients to monitor their journey.

This system would allow for better forecasting of demand based on urgency. With the appropriate models for costing surgical care, it would be possible to more objectively define funding required to catch up and maintain services for surgical patients, whatever the funding model.

It is vital that we implement this system as soon as possible to accurately predict demand, manage wait lists more effectively, and improve access for all our patients.

—Andy Hamilton, FRCPC, CCPE
Summerland

How you can help Syrian refugees

Canada has committed to accepting 25 000 refugees from the ongoing civil war in Syria. BC is expecting to welcome up to 3500 by the end of February 2016. A portion will already be in the province by the time you read this letter.

Many physicians will have also read my related blog posting on the *BCMJ* website. Some will have signed on to Medavie and will already be engaged with individual sponsors, Immigrant Settlement Services of BC, or the Bridge Clinic in Vancouver to provide care or advice to these newcomers to BC. What these physicians will know is that every refugee will have undergone a comprehensive medical assessment prior to entering Canada. Although the physical health of many will have deteriorated from the relatively good health enjoyed by Syrians prior to the onset of civil war, these new arrivals will pose no threat to the health of Canadians. According to the World Health Organization, the incidence of TB in Syria was low (17 cases per 100 000 population), and refugees examined in Europe have shown low levels of infection. Any cases contracted in refugee camps will be identified during the medical examination and treated prior to entry into Canada. Syria also had high levels of coverage of routine childhood vaccination—reaching an estimated 90%. However, since the onset of the civil war, reductions in health infrastructure and lack of access to health care as refugees travel to safer havens means that many children will be undervaccinated or not vaccinated at all. You can expect more information regarding the refugees' overall health status and gaps as we gain more experience.

The demographic profile that we expect to see is one of younger families. Many of the health issues they face will reflect the hardships they have endured. We will need to ensure that systems are in place to address health issues over time, including physical trauma, malnutrition, psychosocial trauma, and dental problems. We also need to be prepared to provide treatment for chronic diseases such as cardiovascular disease, hypertension, and diabetes. Once the refugees have recovered physically and are becoming integrated into Canadian society, it is possible that the focus of care and support will need to shift to the lasting psychological effects of their experiences.

These refugees will, by and large, already have access to immediate Medical Services Plan coverage and will not have to wait to access provincially covered care in BC. They will also be eligible for supplemental coverage through the Interim Federal Health Program (IFHP). The IFHP will cover services such as dental care, mental health, and additional medications, over and above what is covered through MSP.

To access primary care if they do not have immediate MSP coverage or require additional health services, refugees must be treated by physicians or health professionals who have signed up with Medavie Blue Cross, which is the IFHP claims administrator. Once you have signed up with that program, potential patients are able to find you through a list of eligible providers.

To sign up with Medavie, visit www.cic.gc.ca/english/refugees/outside/arriving-healthcare/practitioners.asp.

If you'd like to help, here is how to get involved. I encourage you to contact the Immigrant Services Society of BC to let them know that you are able and willing to accept refugee patients (both those with MSP coverage and without). If you are worried about a language barrier—many of the refugees will likely not speak English (at least not fluently)—the Provincial Language Service has stepped up efforts to hire additional Arabic-speaking interpreters who can provide health-related translation services. Thank you for helping.

—Perry Kendall, OBC, MBBS, MSc, FRCPC
Provincial Health Officer

Postscript: Doctors of BC has created a webpage to keep members informed of resources and information available to provide medical care for Syrian refugees. Check the page regularly as it will be continually updated: www.doctorsofbc.ca/caring-syrian-refugees.

Re: Diagnostic testing for Lyme disease

Thank you to Drs Kling, Galanis, Morshed, and Patrick of the BC Centre for Disease Control for providing some badly needed evidence to counter patients' claims of better tests for Lyme disease, in their November article "Diagnostic testing for Lyme disease: Beware of false positives" [*BCMJ* 2015;57:396,399]. Not everyone understands that the accuracy of a test, investigation and also symptoms and signs, is made up of two characteristics: its sensitivity to diagnose disease (true positives) and its specificity to rule out disease (true negatives). These two characteristics move in opposite directions—as sensitivity goes up specificity goes down and vice versa.

Happily, they can be combined into a single number that expresses the discriminating power (or diagnostic power) of a test. Correcting sensitivity for its lack of specificity, and specificity for its lack of sensitivity, and adding the two numbers together provides a single, unitless number on a scale of 200. For the data shown in the article, the reference two-step testing yields a discriminating power of 94.6 (or 47.3%), while the alternative laboratory testing yields a discriminating power of only 2.7 (or 1.35%). Armed with these simple figures it should be easier to convince patients of the futility of looking elsewhere for better tests.

—Gerald Tevaarwerk, MD
Victoria

Additional reading

Tevaarwerk GJM. Measuring the efficacy and cost-effectiveness of laboratory tests. Ann R Coll Phys Surg Can 1995;28:217-220.

Authors reply

We thank Dr Tevaarwerk for introducing another important concept in summarizing the value of a diagnostic test. By any measure, we would also conclude that the reference test is vastly preferable to the alternative, but we see value in continuing to improve the discriminatory power of reference testing.

—David M. Patrick, MD, FRCPC

Re: BC at GC: Why care?

In the October 2015 Pulsimeter item "BC at GC: Why care? (So long and thanks for the fish)" [*BCMJ* 2015;57:350], Dr Cadesky makes the following statement regarding the Doctors of BC delegation to the CMA General Council: "ongoing issues such as… health human resources (also known as Why Aren't There Enough Jobs for Surgical Specialists?)." The statement deserves comment.

A call to action on health human resources was triggered by increasing complaints from specialists who failed to find jobs after completing their training. Note the absence of the term *surgical* in front of the word *specialist* as not only surgeons have reported difficulties. However, the statement fails to mention that there are also too few of certain specialists to address unfilled job positions. Note the absence of the words *patient care needs*. This seems to be a recurring theme in these discussions. Doctors worry about doctors with no mention of the bigger pictures of residency planning mismanagement and patient care. Medical students are turned away from specialties that are in need of physicians and directed toward specialties that have an overabundance of physicians. The ultimate tragedy is that patients are unable to access timely health care.

Why is this misalignment of resources happening? Is it just poor planning or a complete lack of planning? No matter the reason, it needs to be addressed immediately. And the health human resource management needs to be affordable, sustainable, and fit for the purpose.

There is a profound silence and lack of immediate effective action. The lack of data is decried, but the difference between no data and some data is quite obvious—some data will improve decision making. The difference between some data and enough data is not so clear but should not delay decisions. The Medical Human Resources Planning Task Force has no dermatology member, has never asked for dermatology input, and has never reported to dermatology. I suspect other specialties have the same experience. Let's roll up our sleeves and work together.

The 2014 and 2015 National Physician Employment Summits hosted by the Royal College of Physicians and Surgeons of Canada produced little of substance, so we need to think nationally but act provincially.

—Evert Tuyp, MD, President,
BC Section of Dermatology