BCMJ BC Medical Journal

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Medicinal cannabis: Concern with College standard

Medicinal cannabis presents a unique dilemma for physicians and regulatory authorities because it represents an unapproved treatment with limited good-quality research to inform guidelines that clarify specific age-related indications, dosage, or risks. In addition, many myths portray negative effects, which results in a culture of ill-informed lack of medical support. Despite these barriers physicians have been designated as the gatekeepers of access to cannabis for medical purposes. On 5 May 2015 the College of Physicians and Surgeons of British Columbia (CPSBC) published a standard entitled *Marijuana for Medical Purposes*, to set out the professional requirements of physicians in BC who plan to support patients in the use of cannabis for medical purposes.

Practitioners for Medicinal Cannabis (PMC) is a nationwide network of specialists and general practitioners among whom there is extensive clinical experience in the medicinal use of cannabis. PMC is committed to best possible patient care, including the informed use of cannabis and cannabis-derived products. As participants in PMC, we write as a group of physicians to share with readers of the *BCMJ* our concerns about some of the statements included in the CPSBC standard. We also offer access to an information resource and networking with PMC.

PMC concerns

First, we consider that the CPSBC standard fails to acknowledge or accommodate the unique and complex nature of cannabis, or how it is used for medical purposes. Cannabis is not a single therapeutic entity. The plant contains many different physiologically active compounds with a wide variety of potential therapeutic uses. Different strains possess a different balance of components, specifically in the balance of THC to CBD. In spite of the commonly held perception that cannabis is smoked, there are other safer, less stigmatized ways to prepare cannabis for therapeutic applications. Effects of a particular product on one clinical situation cannot be assumed to apply to

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other products or clinical contexts, and each individual patient's response is unique.

Second, we believe that the CPSBC standard fails to recognize the significance and importance of existing scientific literature. In particular, this includes the enormous and growing literature regarding the body's endocannabinoid system with which cannabis interacts. As many readers are aware, large-scale double-blind controlled trials are not the only resource that informs clinical knowledge. There is a considerable body of sound evidence to support the use of cannabis for medical purposes that also confirms its relative safety, especially compared with other agents.

The CPSBC standard also fails to acknowledge appropriately the context of more questionable studies that underpin some of the well-established but misinformed myths around cannabis. Given the complex nature of cannabis, it is relevant to note that studies that report on or make correlations between cannabis use and specific outcomes, but which don't also take into account or adequately address pertinent variables (THC/CBD content, THC/CBD ratios, confounding factors such as cigarette smoking or other drug use, pre-existing mental health issues, age, genetic factors, and recreational versus medicinal cannabis use), cannot be replicated or confirmed in a meaningful way. It is also questionable whether conclusions drawn about cannabis from studies of recreational users can be extrapolated to its use in a medical context.

Third, we question the appropriateness of the College warnings to physicians who consider authorizing legal access to cannabis. The College's position presents an alarming perspective of a physician's risk in authorizing the use of cannabis; for example, "may be the subject of accusations or suggestions of negligence, including liability if the use of marijuana produces unforeseen or unidentified negative effects." This risk is not substantially different from that of prescribing any other substance or undertaking any medical procedure.

Fourth, we take issue with the College's prerequisite that conventional therapies be attempted before cannabis. The College standard lists eight requirements for physicians. The first of these says the physician shall: "Document that conventional therapies for the condition for which the authorization of marijuana for medical purposes was provided have been attempted to assist the patient in the management of his/her medical condition and have not successfully helped the patient." We are concerned that this requirement does not duly respect a patient's personal autonomy and right to make decisions pertaining to his/her own health care. We recommend that the word "attempted" be replaced by "considered."

Fifth, we are concerned that the CPSBC standard, through its several requirements and restrictions on physician behavior, creates a barrier to care for patients. In addition, the standard does not put the physician's role or the College's responsibility into an appropriate societal context. Federal courts have deemed use of cannabis for approved medical purposes to be a Charter right, protected by the Constitution. The College's mandate of public protection through effective regulation of the medical profession includes protection of those disabled and seriously ill patients who benefit from the medical use of cannabis. The College standard presents considerable challenges for a physician who wishes to provide the professional support that a patient needs in order to exercise his or her constitutional right.

A helpful resource

The College standard lists a number of groups of patients for whom "cannabis is generally not appropriate," but acknowledges that there are circumstances where exceptions may be made. Several members of our group have co-authored a summary of the relevant literature informing the use of cannabis in the care of such patients. Our intention is to provide a clinical perspective and a nuanced discussion to help physicians balance potential risks against potential benefits when considering a trial of a cannabis-derived product for an individual patient.

If any physician is interested in obtaining an online copy of that summary, please contact the Practitioners for Medicinal Cannabis by e-mail at pmcaccess@gmail.com and include "BC standard" in the subject. Any health care practitioner is welcome to participate in PMC, or to submit a question to the network. Through that e-mail address PMC participants share resources and questions about clinical cases, and discuss issues related to the medical use of cannabis.

The following physicians, in alphabetical order, endorse the content of this letter. They are all participants in PMC.

—Donna Dryer, MD, FRCPC
—Caroline Ferris, MD, CCFP, FCFP
—Gwyllyn S. Goddard, BSc, CCFP, MD
—Peter A Gooch, MB ChB
—Philippa Hawley, FRCPC
—Cecil Hershler, MD, PhD, FRCP(C)
—Gill Lauder, MB BCh, FRCA, FRCPC, CPE
—Caroline MacCallum, FRCPC, BSc
—Ian Mitchell, MD, FRCP
—Michael Negraeff, MD, FRCPC
—Conrad Oja, MD, PhD, FRCPC
—Arnold Shoichet, BSc, MD
—Christine Singh, MD, CCFP

College replies

The College appreciates the opportunity to respond to a letter regarding its professional standard, *Marijuana for Medical Purposes*. According to the Health Professions Act (HPA), the role of the College is to establish, monitor, and enforce standards of practice to reduce incompetent, impaired, or unethical practice. The regulation of medical marijuana is an obligation that medical regulatory authorities across Canada have been reluctant to take on. The revisions to the Medical Marijuana Access Regulations essentially removed Health Canada from any oversight of the use of this substance.

When the College's Ethics Committee drafted the standard regarding medical use of marijuana, it reviewed the considerable experience of the state medical boards that have been regulating this aspect of practice for a while. Published and personal reports

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emphasized the importance of documenting a professional interaction with the patient, which includes taking a history, conducting an examination, considering a differential or provisional diagnosis, formulating a treatment plan, and following the patient. It may seem unnecessary to remind physicians to act professionally in this regard, but multiple instances of documents being signed with no or minimal patient interactions had been identified. The College did not want to have the entire profession disgraced because of a few individuals exchanging their signature for a fee—and not much else.

Turning to the specifics in the letter, the College standard is not a clinical practice guideline so it does not address how marijuana is used for medical purposes. The paucity of scientific evidence is acknowledged by the authors of the letter, and is noted on the Health Canada website as well as the College standard. The College doesn't evaluate studies, scientific or otherwise, in the context of ethical and professional standards. This is the purview and responsibility of subject matter experts who draft clinical practice guidelines.

With respect to the cautions in the standard, the College is reminding physicians that as a natural substance, marijuana use is not without potential harmful effects. Given the high rate of recreational use and the lack of legal access to marijuana, the lines between true medical use and convenience for recreational use are blurry. Even in jurisdictions that authorize medical use and lawful recreational use, recreational users may still seek out medical authorization because it is cheaper.

The College is encouraged that the federal government is moving to legalize recreational use of marijuana. This will no doubt alleviate pressure on the existing medical access pathways. The foundation of the College's standard—that medical marijuana is a treatment decision based on a professional interaction with the patient, weighing the unique risks and benefits for each patient, and in the context of a longitudinal relationship—is to ensure good medical practice.

Readers may wish to review the Federation of State Medical Boards' *Model Guidelines for the Recommendation of Marijuana in Patient Care*, adopted as policy in April 2016. Like the College standard, the guideline addresses similar important topics: the physician-patient relationship, patient evaluation, informed and shared decision making, treatment agreements, qualifying conditions, ongoing monitoring and adapting treatment plans, consultation and referral, medical records, and physician conflict of interest.

The College hopes that continued research and the development of pharmaceutical cannabis-derived products provided through traditional prescription/pharmacist dispensing will soon be reality. When recreational use of marijuana is legalized, taxed appropriately to increase revenues for the publically funded health care system, and sold responsibly through provincial agencies that have a solid track record of not selling alcohol to children, physicians will be able to perform their customary role where substance use is concerned: counseling patients to moderate their consumption.

—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: Ah, the good ol' days

The editorial "Ah, the good ol' days. Nary an orphan in sight." (*BCMJ* 2016;58:244) provided a simplistic description of the growth of hospital medicine (a.k.a., hospitalist programs) in BC. It also included a number of misleading statements.

For example, the author claims that "patients who were cared for by their own GP had shorter hospital stays" than those cared for by hospitalists. No references are provided to support this claim. In fact, numerous studies in the United States, and some limited evidence from Canada, have shown the opposite—hospitalists reduce length of stay compared to nonhospitalists,[1-3] while reducing hospital costs and possibly also improving quality of care.

There are clearly advantages to the traditional model of inpatient care provided by a patient's own GP. Good continuity of care is the most obvious example. I have great respect for the dedication of my GP colleagues who maintain busy community practices as well as hospital privileges. The medium-sized community where I work is fortunate to have a strong hospitalist department that has regular contact and an active collegial relationship with the community-based family physicians, both those with and without active hospital privileges.

—Scott D. Smith, MD, CCFP, MSc
Hospitalist, Kelowna

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The editor replies

Thank you for your response letter to my editorial. I have great respect for my hardworking hospitalist col-

leagues and meant no disrespect. My piece reflects the statistics and experiences at my hospital and was meant to be a tribute to the valuable contribution made by family physicians through the years.

—Ed

Re: Addressing existential suffering

I enjoyed reading Dr Bates's excellent article on addressing existential suffering in patients with terminal illnesses (*BCMJ* 2016;58:268-273). Spiritual/religious issues are important for many of our patients, not just those facing end-of-life issues. A study of 2000 physicians published in 2007[1] indicated that most psychiatrists and nonpsychiatric physicians believe that religion/spirituality helps patients cope with and endure illness and suffering by offering a positive, hopeful state of mind and/or a community that offers emotional or practical support. Over the years I have recommended that medical students, psychiatry residents, and residents in other disciplines routinely ask patients about their spiritual beliefs and how they would like them to be addressed. Dr Bates included a copy of the FICA spiritual history tool in his article. I would highly recommend that the FICA be used routinely with patients, especially those who have chronic illness and suffering. It could be used as a brief screening tool, similar to the CAGE questionnaire, which is commonly used to screen for alcohol/substance abuse. Over the years I have seen no negative effects from asking patients about spiritual issues. Instead, it usually improves rapport and contributes to a positive doctor-patient relationship. Patients can be referred to appropriate spiritual care resources as needed, but physicians should not neglect identifying important spiritual/religious issues that may be affecting a patient's well-being.

—Stephen D. Anderson, MD, FRCP(C)
Clinical Associate Professor, UBC Faculty of Medicine, Dept. of Psychiatry

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Re: Thoughts on professionalism

In response to our president's "Thoughts on professionalism" in the June issue (*BCMJ* 2016;58:247), I would like to add comments pertaining to his third tenet of our profession's longstanding tradition—the value and merit of the social contract.

This longstanding tradition of a historically great and independent profession predates this country's tiny historical anomaly of forced and unconstitutional social contracts—a contract that is with the state rather than with the patient, contrary to our Hippocratic Oath. Forced because we have a single payer that has legislated a monopoly, and because doctors must travel abroad to change their employers. Unconstitutional because it is a rationing monopoly, at least hurting patients in need.

The issue has become far more concerning recently for patients and physicians alike because the topic of physician-assisted death now also raises the uncomfortable question of whether physicians have finally become de facto agents of the state in this country.

Since professionalism is rather defined by skills, good judgment, and polite behavior that is expected from a person who is trained to do a job well, we should ask ourselves: where has our collective independence of thought and actions necessary to support good judgment gone lately? And

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will our patients be better off for its apparent absence?

Advocacy for our patients should be the real cornerstone of our profession, and it requires independence. Fighting internal and external factors that degrade our ability to advocate and care for patients and reverting the erosion of our profession is the ultimate healing goal for the profession itself.

This social contract that imposed itself slowly across several generations, by misrepresenting the original aim of Tommy Douglas, can only be seen as a clumsy ideological vestige of the past. It interferes with our primary commitment: our patients.

Dr Ruddiman, what we are fortunate to have is not that social contract but a direct contract with our patients, and having had an opportunity to acquire an amazing education (rapidly paid back with income tax), lifesaving skills in a very rewarding profession—an old one indeed—all these transcending ideology, generations, postal codes, and bureaucrats. That should be the foundation of our independence.

Our problem is then that we, as a profession, no longer believe that we belong to a great independent profession; rather, we subject ourselves to whatever master of the day is willing to pay us. Mercenaries, agents of the state, whatever you may want to call us, we are no longer the healers of the Hippocratic Oath. The legacy will not be excellent 21st-century medical care and we will be remembered as enablers who replaced the Hippocratic Oath with an oath (little "o") to the state. And isn't that what we do not want to become!

—J.N. Mahy, MD, FRCSC, FACS
Burnaby

President replies

Thank you, Dr Mahy, for sharing your thoughts on the milieu of medical professionalism. This is to be considered as each of us sets out every day to deliver the highest quality of care to all patients across British Columbia. While I agree that physicians would gladly embrace greater independence within our health care system, it is not necessarily the cornerstone with which to effectively advocate on behalf of our patients. Every day, individually and collectively, we as a profession effectively advocate on behalf of our patients, both for their needs and those of our health care system. Doctors of BC is now enhancing this advocacy on behalf of the profession with the development of medical staff associations all across our province to support and grow physician leadership, our influence, indeed our very independence.

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

Safe prescribing (1)

I and every doctor in British Columbia received the new College of Physicians and Surgeons of BC professional standards on safe prescribing last week to address the public health emergency related to opioid overdoses. This is a new professional standard to assist physicians with the challenging task of prescribing opioids, benzodiazepines, and other medications. This was adopted to "direct appropriate prescribing of potentially harmful drugs," and "these professional standards are not discretionary and must be adhered to." We are all directed to document discussions with our patients about the benefit of pharmacologic and non-opioid therapies for the treatment of chronic pain.

The College accepts aggressive pharmacotherapy in the context of active cancer, palliative, and end-of-life care. But it frowns on continuing to prescribe opioids to patients with chronic noncancer pain who, usually, after everything else has been tried and failed, need narcotics as an add-on or replacement (usually due to adverse events) for other modes of treatment.

We are to advise our patients that long-term opioid therapy is not indicated for certain medical conditions, including headaches, headache disorders, and axial low back pain, but if we are at the point of prescribing opioids to a patient in chronic pain then usually everything else has failed.

I have patients with chronic headaches where neurologists have prescribed narcotics because nothing else works. I have patients who have had benzodiazepines added to their narcotic regimen by neurologists and pain clinics so that they can get some sleep. Patients who are nonsurgical candidates for chronic back pain often suffer until opioids are prescribed.

When did it become gospel that patients with a history of addictions or those with psychiatric illness or young people, whoever that applies to, can't suffer severe pain? I attended a medical conference years ago when a well-respected clinical pharmacologist asked, "Would you rather have a patient in chronic pain suffer, be bedridden, and/or housebound, and not be on narcotics, or be adequately treated and be a productive member of society working, enjoying his/her quality of life, and paying taxes, albeit needing narcotics to do so?" I thought about what he said and changed my whole attitude on treating chronic noncancer pain and have never regretted it.

Yes, patients become dependent on narcotics, but there is a difference between dependence and addiction. We have patients who are dependent on antihypertensive medications, on thyroid medications, on diabetic medications, and the list goes on. We also have patients dependent on narcotics and if that's what it takes for them to have some quality of life and function normally, or as close to normally as possible, then I am all in favor of prescribing narcotics.

I have no problems with the Col-

lege's new standards, but what do they recommend I treat my chronic pain patients with? Many cannot tolerate nonsteroidal antiinflammatory drugs (NSAIDs). (It is said more people die from NSAIDS in Canada than all of the traffic accidents combined.) NSAIDS are contraindicated in so many situations—chronic kidney disease, heart problems, gastrointestinal bleeds, etc. Tylenol is minimally effective, if at all, in patients with anything more than mild pain, especially in the geriatric population.

We send our difficult patients to pain clinics, and after a prolonged wait for usually minimal benefit, rarely, if ever, do they suggest to taper or stop opioids.

Studies have shown it to be safe to drive, etc., in those with steady-state narcotic administration. I will gladly stop prescribing opioids for chronic pain, but tell me what should I prescribe?

My prescribing habits can easily be monitored through PharmaNet and the duplicate prescription program. Those who are prescribing out of range can be audited and disciplined if they can't justify their prescribing, but leave the rest of us alone to care as best we can for our patients in pain.

Not all patients are con artists or junkies. Not all doctors are inappropriate prescribers. We care about our patients and hate to see them suffer but our options are limited.

I have yet to have a specialist in pain, surgery, physiatry, internal medicine, etc., suggest I stop narcotic prescribing for appropriate indications, and I have been practising for a long time.

Give me readily accessible, workable alternatives to narcotics when all else fails or leave me alone!

—Stephen M. Shore, MD, CCFP
Langley

College replies (1)

The College fully appreciates the difficulty in treating patients with medical conditions or symptomatology for which an effective treatment cannot be found, or for which the patient is unable to pay.

Safe Prescribing of Drugs with Potential for Misuse/Diversion was developed over the past year because the previous document, entitled *Prescribing Principles*, failed to prevent an increasing toll of prescription drug misuse and overdose deaths in this province. Additionally, clinical guidelines developed by NOUGG in 2010, an initiative sponsored by this and other Canadian medical regulatory authorities, have also apparently not been effective in preventing the increasing reliance of prescribers on long-term opioid treatment for chronic noncancer pain.

There is an excellent summary of the current medical evidence and expert opinion in the US Centers for Disease Control and Prevention's *Guidelines for Prescribing Opioids for Chronic Pain*. The conclusion of the experts is that opioid treatment for chronic pain provides small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harm.

While there is limited evidence of the long-term benefits of non-opioid therapies, the risk of harm is clearly far less and thus they should be considered preferred treatments. Nonpharmacologic therapies can include exercise and physical therapies as well as psychological therapy such as cognitive behavioral therapy. Not all of these approaches have to be in the context of multidisciplinary programs, which many patients are unable to afford.

The College's statutory mandate is public protection, and the purpose of this professional standard is to reduce inappropriate prescribing of certain classes of medications. The College cannot address all of the societal problems that make the treatment of patients with chronic noncancer pain so challenging; however, it can try to reduce the additional harm that is caused by unsafe pharmacotherapy.

—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

Safe prescribing (2)

In an unprecedented move, the College of Physicians and Surgeons of BC (CPSBC) introduced the professional standards and guidelines *Safe Prescribing of Drugs with Potential for Misuse/Diversion* as a legally enforceable policy on 1 June 2016.

The standard extends the US Centers for Disease Control and Prevention's (CDC) *Guideline for Prescribing Opioids for Chronic Pain* to include stimulants and sedatives.

The CPSBC gave no reasons for rejecting the evidence-based Canadian *Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* or adopting the CDC guideline as a standard.

The CPSBC did not consult the Pain Medicine Physicians of BC Society (PMPoBC) or Pain BC, the key organizations representing physicians with focused pain practices and the one in five British Columbians living with persistent pain.

The PMPoBC wants to minimize harm from drugs we prescribe. However, we are very concerned that enforcing the standard will diminish quality of life in the majority of patients who do not misuse, divert, or become addicted to opioids, sedative, or stimulants. The CPSBC appears to accept this consequence.

The PMPoBC is very concerned that, given the lack of access to interdisciplinary pain clinics and community-based physical and psychological therapies, some patients will seek illicit drugs to relieve their conditions which will further escalate

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the current public health emergency. We also hope that physicians do not withdraw from managing persistent pain because of mandated restrictions to their practices.

The PMPoBC has written to the CPSBC seeking clarification of many statements in the standard, including those mandating maximum daily doses of opioid and prohibiting trials of opioids in certain conditions, including many psychiatric disorders. We have offered to help the CPSBC revise their standard. We await their response.

—Owen D Williamson, MBBC, FRSCS, FFPMANZCA
President, Pain Medicine Physicians of BC Society

College replies (2)

The development of this or any other professional standard is not "unprecedented." The College has a statutory obligation to set standards for medical practice, and most elements contained in the standard on safe prescribing have appeared in successive versions developed by the College's Prescription Review Program entitled Prescribing Principles. The College has been using the prescribing principles in its work with registrants for more than 3 years. Hundreds of BC physicians have successfully operationalized them in their practices—by that measure, they are extensively field tested in real-life clinical settings.

With respect to strong opioids for chronic noncancer pain, successive, authoritative systematic reviews by Furlan,[1] Ballantyne,[2] Chou,[3] and colleagues suggest that, on average, there is weak evidence of modest relief of pain for a period of weeks or a few months, with minimal functional improvement, not superior to naproxen or nortriptyline. Dr Chou's recent paper in the *Annals of Internal Medicine* documents accumulating epidemiological evidence of harms, including addiction and death. This is not to say that some patients do not benefit from long-term opioid therapy, only that the benefit is very modest, the risks significant, and the evidence tentative, despite over 20 years of escalating prescribing.

While the College participates in a consultative process during the development of professional standards, it cannot and must not abrogate its legal obligation to regulate medical practice, including prescribing. Regulation is foundational, and the advice in the standard is deliberately formulated in general terms, allowing flexibility for bedside clinical judgment. Nothing in the standard prohibits or even materially interferes with the ability of pain specialists or other physicians to safely and effectively care for their patients.

The College shares concerns that services for patients who suffer from chronic pain are often difficult to access or navigate. Solutions to that are beyond the mandate of the regulator. What is within the College's mandate is the ability to investigate any report of physicians misapplying the standard to the detriment of patients.

—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

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2. Ballantyne JC, Shin NS. Efficacy of opioids for chronic pain: A review of the evidence. Clin J Pain 2008;24:469-478.
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Safe prescribing (3)

The Section of Psychiatry is both disappointed with and concerned about the new professional standards and guidelines for *Safe Prescribing of Drugs with Potential for Misuse/Diversion* put into effect by the College of Physicians and Surgeons of BC on 1 June 2016. We believe that the release of this document reflects a striking failure of due diligence, and a major misstep in the College's fiduciary duty to guard public safety.

By codifying so many complex clinical decisions as standards instead of guidelines, the College has intruded into the doctor-patient relationship in an unprecedented fashion. Limiting opioid dosing to an absolute, no-exceptions maximum of 90 mg of morphine equivalent per day is one such example. In clinical practice, patients' requirements, physiologies, conditions, and options/alternatives are often highly divergent. Protection for patients on stable, responsible, enduring, and successful opioid treatment regimens that happen to be in excess of this arbitrary figure—and there are many—is lacking in this document.

That the College does not explicitly make an exception for active cancer, palliative, and end-of-life patients is an unconscionable oversight that requires formal revision immediately.

Our biggest concern is the College's failure to account for the welfare of the many British Columbians suffering from chronic mental illness. The idea that someone who needs a benzodiazepine for treatment of a complex sleep disorder, or a psychostimulant for severe ADHD, now does not have the option of receiving basic ongoing opioid pain control medication if needed—unlike every other patient in the province—is frankly discriminatory. By failing to clearly define "sedatives," "stimulants," and "psychoactive medications," and by painting such treatments with the same brush used for Schedule I drugs, the College further stigmatizes the mentally ill.

The Section of Psychiatry is extremely supportive of well-considered and effective strategies and initiatives that aim to reduce the risk of harm to the public. This document, clearly produced without meaningful input from psychiatrists, will leave physicians in certain cases facing the dilemma of either disregarding standards published by their regulatory body, or compromising patient care. We object.

—Steve Wiseman, MD
Chair, Economics Committee,
BC Psychiatric Association
—Carol-Ann Saari, MD
President, BC Psychiatric Association

College replies (3)

Safe Prescribing of Drugs with Potential for Misuse/Diversion was developed over the past year as an evolution to a previous document entitled *Prescribing Principles*, which failed to prevent an increasing toll of prescription drug misuse and overdose deaths in this province. The decision to reframe what is essentially the same advice as a standard rather than a guideline was based on what the College saw as a need to provide more authoritative direction to the profession in the context of Dr Perry Kendall's recent description of BC's health care emergency of opioid misuse and overdose.

The authors write that the professional standard does not explicitly make an exception for active cancer, palliative, and end-of-life patients. In fact it does, but perhaps greater clarity or emphasis on this point would be helpful when the standard is next reviewed.

The College does not accept that the professional standard in any way fails to account for the welfare of patients with mental illness or contributes to the stigmatization of these patients. A large part of the impetus to provide more authoritative direction for safe prescribing was evidence before the College—that it is often patients with concurrent diagnoses of mental illness or addiction who are the victims of the adverse and sometimes fatal side effects of inappropriate long-term opioid treatment.

—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

EHRs and burnout (a.k.a. early retirement)

A recent article in the *Globe and Mail*, included in a Doctors of BC newsflash, led me to write about electronic health records (www.theglobeandmail.com/life/health-and-fitness/health/doctors-using-electronic-records-at-higher-risk-for-burnout-study/article30652673/).

EHR adoption has not included provisions for transcription of pre-existing records/history. EHRs have been a boon for the regional health authorities in British Columbia—gathering of big data to allow further simplification of complex realities and ultimately leading to more homogenization and standardization of our (ideally) complex relationships with real people (patients) on the ground. Bonus incentives for management that are modelled on the corporate sphere make the mining of big data without a thorough understanding of the front-line complexities dangerous. With an agenda to make it easier to have the appearance of accountability and standardization of care, the data are often used to justify reduced real services on the ground and increased micromanagement.

I would hypothesize that in family medicine, burnout leads to a decreased ability to be our patients' advocates in navigating the idiosyncrasies of non-transparently rationed care, less face

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time with patients, and more errors, thus justifying a need for more quality assurance and more idiot-proofing built into the EHRs, followed by a need for constant improvements (i.e., not intuitive patches that are usually inconsistent with the original operating platform), and resulting in EHRs that are even more rigid and frustrating. It's a positive feedback loop and more business for the IT industry. The apparent smartness of drop-down menus and rigid algorithms have reduced flexibility and fit, as well as satisfaction and connection, which are essential in family medicine. Many of us may retire earlier than we otherwise would have, not because we don't get it and are too rigid to learn, but rather because we do.

—Andre C. Piver, MD
Nelson

Re: The impact of excessive endurance exercise

First, thank you for a very important and well-written article [*BCMJ* 2016;58:203-209].

I took a look at the four recent studies that were discussed in the "How much exercise is enough?" section and wonder if you can shed light on something. The clearest U-curve is found in the study on Copenhagen joggers.[1,2] The study on runners in Texas[3] also showed a U curve though it was less striking. The study on all forms of exercise in Taiwan,[4] however, showed a continued benefit with longer and more vigorous exercise.

The main differences in these studies that I found were:

1. Difference in race: East Asian versus two white populations.
2. Difference in exercise modality: running versus all forms.
3. Difference in follow-up period: The study in Taiwan was only 8 years of follow-up, which is less than in Copenhagen or Texas, though the subgroup analysis in Copenhagen[2] was also around this length and showed a marked U-curve.

I didn't see any obvious differences in other subject characteristics, though I may have missed something.

Are there any other studies suggesting differences in exercise benefits among different races or exercise modalities?

Thanks again for a stimulating article!

—Joel Fox, MD (PGY-1 Psychiatry)
Vancouver

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Authors reply

We would like to thank Dr Fox for his comments. The studies mentioned are population cohort studies looking at a wide range of individuals with varying activity and fitness levels. The Taiwan study[1] attempted to define the minimal amount of exercise required and looked at all comers in a standard medical screening program. They did demonstrate that higher levels of moderate or vigorous activity conferred no additional health benefits and, thus, more of a reverse J-shaped curve than a U-shaped curve. Given the scope of this review, which focused on excessive endurance exercise, we have focused on those at the extreme end of these mortality curves. The other related articles in the April and May issues of the *BCMJ* may provide more insight into the specific benefits of exercise, since it is clear that moderate exercise is beneficial. The specific studies mentioned are all observational studies with inherent limitations. There are other similar studies not included in the scope of the review that demonstrate similar U-shaped curves or reverse J-shaped curves, but there appears to be a consistent signal that further benefit and potential harm may lie at the extreme end of exercise. To our knowledge, there are no randomized studies that directly compare differences in exercise modality on cardiovascular morbidity or mortality. Overall, our take-home message is that we know moderate and even high levels of exercise appear to show benefit, but the upper limit at which adverse cardiac effects occur is not known.

—Andrea K.Y. Lee, MD
—Andrew D. Krahn, MD

Reference

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