letters to the editor

We welcome original letters of less than 300 words; they may be edited for clarity and length. Letters may be emailed to journal@doctorsofbc.ca, submitted online at bcmj.org/submit-letter, or sent through the post and must include your mailing address, telephone number, and email address. All letter writers will be required to disclose any competing interests.

Re: Water, water everywhere but not a drop to drink

Dr Maheswaran raised the concern of clean-water insecurity for the Indigenous peoples of Canada (*BCMJ* 2018;60:195). The effects include infections, mental and physical stress, diabetes, and dental caries.

Mr Mosa and Ms Duffin outlined the history of mercury poisoning of the Grassy Narrows First Nation along the English–Wabigoon river system in Ontario compared to an industrial incident in Minamata, Japan. The poisoning in Ontario was due to mercury contamination from a pulp and paper mill some 50 years ago.[1] The mercury levels downstream of the plant should have returned to normal by now; however, recent tests revealed much higher mercury levels downstream compared with upstream locations, from unknown sources.[2] The mercury poisoning continues to affect the health, economy, and culture of this Indigenous community.

Federal and provincial governments should act urgently to ensure Indigenous peoples have access to clean, safe drinking water wherever they live in Canada.

—H.C. George Wong, MD, FRCPC

References

1. Mosa A, Duffin J. The interwoven history of mercury poisoning in Ontario and Japan. CMAJ 2017;189:E213-215.
2. Wong HCG. Mercury poisoning in the Grassy Narrows First Nation: History not completed. CMAJ 2017;189:E784.

Re: Best practices in treating chronic noncancer pain

I was disheartened to see that Dr Peter Rothfels, in his article "Best practices in treating noncancer pain"[1] chose to use United States data and an Ontario study about emergency physician prescribing to back up his claim that, "since the mid-1990s, physicians have been increasingly prescribing higher doses and stronger opioids for their patients, particularly those with chronic noncancer pain." Being the chief medical officer for WorkSafeBC, I would presume this article is addressed to BC physicians and their prescribing.

Prescribing of opioids varies dramatically across Canada.[2] BC's mortality rate of 3.9 pharmaceutical opioid-associated deaths per 100 000 population has remained stable from 2004 to 2013.[3] This rate includes all pharmaceutical opioid deaths (including methadone for maintenance), intentional and unintentional, prescribed, and diverted. This pattern is strikingly different from the pattern in Ontario and the United States. The BC coroner, in reviewing prescription opioid deaths in BC from 2009 to 2013,[4] found that methadone, used as opioid agonist therapy, accounted for 30% of the deaths, and that 25% of the deaths involved codeine. In 97% of these deaths, multiple other prescribed and nonprescribed substances were involved.

Any death that implicates a prescribed drug should be investigated in order to prevent further harm, and physicians should be made aware of the outcomes of these investigations.

The narrative that implies that BC physicians have been prescribing more opioids and in greater doses leading to increased harm is not accurate.

—Romayne Gallagher, MD, CCFP(PC), FCFP
Vancouver

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1. Rothfels P. Best practices in treating chronic noncancer pain. BCMJ 2018;60:244,269.
2. Canadian Institute for Health Information. Amount of opioids prescribed dropping in Canada; prescriptions on the rise. Accessed 19 July 2018. www.cihi.ca/en/amount-of-opioids-prescribed-dropping-in-canada-prescriptions-on-the-rise.
3. Gladstone E, Smolina K, Morgan SG. Trends and sex differences in prescription opioid deaths in British Columbia, Canada. Inj Prev 2016;22:288-290.
4. BC Coroner's Service & BC Ministry of Health. Preventing pharmaceutical opioid-associated mortality in British Columbia: A review of prescribed opioid overdose deaths, 2009-2013. Accessed 19 July

2018. https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/pharmaceutical-opioid-mortality.pdf

WorkSafeBC declined to respond. —Ed

Sale of MD Financial Management

The sale of MD Financial Management to Scotiabank has been very unsettling to me and to many of my colleagues. This subsidiary of the CMA has been an integral part of the financial planning and retirement security for Canadian physicians for the past 50 years. An overwhelming number of the physicians I know supported MD Management because it felt safe. The physicians owned the company. The financial agents did not work on commission. They worked solely for us. The fees were the lowest in the investment community. It will be hard to convince us that this will not change. No company spends $2 billion without a plan for a significant return on their capital investment.

The following excerpt from the MD Financial Management website demonstrates the special relationship it has had with Canadian physicians:

> Owned by the Canadian Medical Association, MD Financial Management has the only business imperative of enhancing physicians' financial outcomes by focusing on their distinctive needs and operating in their best interests . . . MD's Advisors work on salary, not commission. Without incentives to sell any particular product, our Advisors provide objective advice that is in our clients' best interests . . . Our priority is for clients to meet their financial goals, not for us to maximize corporate profits.

We were all blindsided by this event. There was no debate, no proposals, and no inclusion of the membership. Why would the CMA even consider selling this trusted institution that dealt with the financial security of its members?

Questions to the CMA:

1. Why was this done?
2. Why was the membership not consulted? Why didn't the CMA float the idea to the membership long before entering negotiations? (They may talk about financial confidentiality, but that is disingenuous. Confidentiality does not apply to a theoretical discussion that the CMA should have had with their colleagues prior to embarking on the strategy.)
3. What happened to the $2 billion? What were the commissions paid? Who received them?

The CMA may wish to change its mission statement, as posted on the MD Financial Management website, as it is no longer valid: "MD Financial Management supports the CMA and enhances the CMA-PTMA membership experience by helping members achieve financial well-being from medical school through retirement."

The CMA abdicated this responsibility and it was done in a secretive, noninclusive manner. It may have been legal, but it was also shameful.

I encourage the physicians of BC who share these concerns to communicate with the *BCMJ*, Doctors of BC, and the CMA. If you would like to be added to an email distribution group on this subject, please contact me at kenmarkel@hotmail.com.

—Ken Markel, MD
Richmond

Re: Sale of MD Financial Management; CMA Board Chair replies

Thank you for taking the time to share your thoughts on our decision to sell MD Financial Management. I appreciate this opportunity to provide some further details and hopefully answer some of the questions you raised.

First, I want to say that this was not an easy decision to make, nor was it a process our members were used to. At the CMA, we're known for our consultations with members and we pride ourselves on it. Understandably, not being able to participate in this process was upsetting for some members and seen as a break from our usual consultative approach. Let me say that we would have much preferred to be able to discuss the sale with members ahead of time, but it simply wasn't possible for the protection of clients and staff and because of the nature of this type of transaction.

I can assure you that we've landed with an organization that can help us serve our clients even better. In fact, a key principle of our agreement is to offer services that are the "same or better." And so, our current products and people are not changing, they're only going to be expanded upon.

I know this is a bold step, but it's also a necessary one. At the end of the day, it would have been very difficult for MD to remain relevant and stay competitive given the way the financial industry is changing. With a new owner, MD will be able to expand its products and services and technology platforms while still providing the objective advice that it's known for. MD's advisors will remain salaried and noncommissioned. MD's main goal remains: to help Canada's physicians and their families achieve financial well-being.

Over the coming weeks, the CMA will be creating an investment board to be the steward of the proceeds of the sale. We'll be working closely with members to map out the best areas where we can effect impactful change and create programs to support physicians and better health in support of the CMA's vision and mission.

I believe, more than ever, that there's a need for a strong, national association to act on the issues that matter to all of us—physician

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burnout, support for medical students and residents, and improved health care. The CMA is now better positioned than ever to be that leader and to be a strong voice for medicine for decades to come.

I do hope I've addressed some of your concerns, but please feel free to contact me at yourvoice@cma.ca with any further questions.

—Brian Brodie, MD
Chair, CMA Board of Directors

Re: Nonrecognized qualifications

Evert Tuyp raises some interesting points in his letter about nonrecognized qualifications (*BCMJ* 2018;60:240). I appreciated the frank and honest editorial comment attesting that the *BCMJ* doesn't have a robust policy on the topic. I wonder whether the College of Physicians and Surgeons of BC, or for that matter governing bodies such as the College of Family Physicians of Canada, have robust policies either. As this issue clearly affects patient safety, public trust, and physician accountability, one would expect them to.

Any policy should provide evidence that nonrecognized training being used in Canada is validated, ethical, and indeed appropriate for patient needs. I have seen many patients who tell me that they have "already seen the specialist" in a particular town, while I am aware that there is no such specialist there. What they had actually seen were proudly displayed certificates of training that is not recognized in Canada, and patients are often completely unaware that this is the case. Perhaps part of any College policy should be a requirement for such physicians to obtain informed written consent from patients acknowledging that they understand when a certificate and training is not recognized in Canada.

—Chris Sladden, FRCPC
Kamloops

Re: Nonrecognized qualifications; College responds

While the College does not collect information from physicians about whether they perform a particular procedure or have a specific expertise or special interest beyond their formal training and academic credentials, it does have an expectation as outlined in the bylaws under the Health Professions Act, and as clearly stated in a practice standard (Advertising and Communication with the Public), that registrants represent themselves and their credentials accurately and truthfully, and that they avoid misleading the public through false or exaggerated claims.

Part 7, Section 7-4(3) of the bylaws states: "A registrant must not identify himself or herself as a specialist unless he or she has certification from the RCPSC or equivalent accrediting body approved by the board."

Part 7, Section 7-4(4) of the bylaws states: "No one other than a registrant who is a certificant or fellow of the RCPSC or who has completed postgraduate training in his or her specialty satisfactory to the registration committee, may indicate on his or her letterhead or office door or otherwise represent himself or herself as holding such specialist qualifications."

Only those registrants who have obtained certification with the RCPSC in a surgical field can refer to themselves as "surgeon."

The College encourages additional training and recognized certification through reputable societies and organizations such as the Canadian Society of Addiction Medicine (CSAM) and the American Society of Addiction Medicine (ASAM). Physicians who provide addiction medicine services come from a variety of professional backgrounds (e.g., family medicine, psychiatry, internal medicine) and, at this time, an established route to certification does not exist through either of the two national certifying colleges. The College recognizes that there are many diploma and certification-granting organizations that sound more impressive than can be verified through independent accreditation of the training program.

Physicians who have obtained membership or certification from a nonrecognized society, or participated in specialized training in a particular treatment or procedure, should be extra vigilant in ensuring that they are not misrepresenting themselves. For example, a family physician who has obtained additional training in treating sport injuries must clearly indicate on any advertising or promotional material that they are a "family physician with a special interest in sports medicine."

The legislation is clear. Physicians can advertise their professional services provided the content isn't inflated and that it genuinely assists patients in making informed choices about their health and well-being.

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