2020 vision, and beyond

Pondering about a new decade on New Year's Day, I thought to myself that not much has changed in the last 10 years. I then shifted on my couch, pointed the remote control at my large-screen TV, and tried to decide between Netflix, Crave, or Amazon. Well, maybe some things have changed. I had to admit that the 2010s included many personal life changing events—I remarried, had two grandchildren, and lost both of my parents.

But on the professional front, is my 2020 general practice so different than it was in 2010? One major change has been the rapid expansion of medications to treat type 2 diabetes. Previously it was metformin, glyburide, then insulin. Now the list is quite impressive and includes DPP-4 inhibitors, GLP-1 receptor agonists, SGLT-2 inhibitors, and stop-stuffing-your-facers. Also notable is the expansion of insulin pump use and, more recently, cutaneous blood glucose sensors—can an external pancreas be far behind? If forced to, I would label the last 10 years as the "mab" decade. Medications using monoclonal antibody technology have exploded onto the scene and, depending which antigen is being targeted, are being used for cancer, autoimmune conditions, and inflammatory diseases. As an aside, I have to laugh at some of the American TV commercials that depict an elderly lady with rheumatoid arthritis frolicking in the sand followed by a minute explaining how grandma could die if she takes "expensivemab."

The past decade also marked our ability to cure hepatitis C. This chronic viral disease led to many cases of cirrhosis, liver failure, and cancer, so what a gift for patients to be able to get rid of this dangerous infection. We also now have a prophylactic medication to reduce the likelihood of HIV transmission in high-risk individuals. Apparently an Ebola vaccine has also been developed and is ready for use.

The exciting world of gene therapy has become a reality.

On a broader scale, the exciting world of gene therapy has become a reality. CRISPR technology allows DNA to be edited by snipping off and replacing genes. The DNA of mosquitoes and mice has been tweaked looking for ways to control malaria and to treat sickle cell disease. Human applications are sure to follow. In addition, therapies using harvested genetically engineered immune cells to target certain tumors are now available. Along the same lines, drugs that release the human immune system by targeting its normal inhibitors are being developed.

On the surgical side there has been an explosion of procedures using scopes instead of incisions. Never has more been done through less. The use of robotic surgery is also expanding. Even 3-D printing is getting in on the action with the production of artificial limbs.

An area that has changed very little, however, is the challenge of finances and costs. Many of these therapies have been priced out of reach of all but the privileged few. Socialized medicine is struggling to keep pace with an ever-expanding array of new and costly therapies.

Regardless of the challenges to be faced and the advances to be made, this decade will likely be the last of my medical career, and I look forward to seeing how medicine evolves as I accelerate over and down the hill. Here's to the roaring '20s! ■

—David Richardson, MD

A constitutional solution for an ailing health system?

What is already one of the longest trials in Canadian history will enter its fourth year in 2020. The similar *Chaoulli* case in Quebec took under 6 weeks. Two main questions are being asked. One is whether Canadians suffering on wait lists outside of Quebec should have the same protection under the Charter of Rights and Freedoms that the Supreme Court of Canada granted to residents of Quebec. The second is whether it is lawful for a government to legislate itself a monopoly on the funding of medical care, promise timely access, fail to deliver it, and then outlaw a citizen's right to access care for themselves.

The trial will go down in history for many reasons. We heard a defendant's witnesses admit that a large health authority was submitting incorrect dates on booking sheets submitted to the government's Surgical Patient Registry. This made children's wait lists appear shorter than they are. We heard a government expert on ethics give evidence that wealthier productive individuals who pay more taxes should, when it comes to access to surgery, be prioritized ahead of others, including children and the elderly. We heard a defendant's expert witness (who swore under oath to be a nonadvocate) acknowledge that his affidavit evidence was researched and edited by the Chair of Canadian Doctors for Medicare, a participating respondent and intervenor in the case. The BC government also hired other "expert" witnesses who have been admonished by judges in other provinces for providing inappropriate and inaccurate evidence in court.

We heard from a surgeon who had been instructed by hospital authorities to reduce the number of consultations he sees in order to make the wait times for surgical procedures appear shorter than they were. His department also received instructions to recategorize priority 4 patients ("moderate to severe pain and functional deficit") to priority 5 ("mild pain, tolerable functional deficit") in order to make the wait lists seem more acceptable.

Few Canadians are aware that Canada is the *only* country on Earth in which there are laws that prevent its citizens from accessing private insurance. Last summer I was invited as an opening speaker at an international conference of health executives being held in Budapest. Delegates from around the world were in attendance. I was invited because of skepticism that a country like Canada could force its citizens to "suffer and die on wait lists" (a phrase from the Supreme Court ruling in *Chaoulli*). Delegates from China were particularly shocked that governments within Canada could claim sovereignty over the health of its citizens. "In China, government limits certain freedoms, but would never prevent an individual from caring for their own bodily health," they said.

Few Canadians are aware that Canada is the only country on Earth in which there are laws that prevent its citizens from accessing private insurance.

It's true that not all Canadians suffer from such restrictions. Exempted are those injured at work, federal employees, nonresidents, and federal prisoners. At trial, uncontested and unchallenged evidence was given to show that representatives of all the groups opposing us in court, including the office of the defendant (the Attorney General of BC), the leadership of Canadian Doctors for Medicare, and the opposing trade unions, used private clinics in BC.

Statistics from the Fraser Health Region showed 308 patients died on their wait list in a single year. Extrapolated nationally, that represents 6500 a year, or about 18 patients a day. In 2007, I wrote an editorial[1] in which I stated, "Injured or sick people who languish on wait lists deteriorate and cost more to treat, in both the short and long term." I argued that a major reduction in wait lists would save billions of dollars. Sadly, patients who die on wait lists represent even bigger savings.

The argument that care should be based on "need and not ability to pay" is one every physician supports. Does our government truly believe that forcing patients to die on wait lists is conforming to that principle? Government tried to block their own wait-list figures from admission at trial. They failed. Their data reveal 30 000 patients waiting longer than the maximum medically acceptable wait time. This includes patients with very urgent needs. Only 30% to 40% of patients with invasive cancers of the cervix, bladder, and prostate are treated within the maximum acceptable time. Their cancers are at risk of spreading while they wait.

In closing argument, government tried to lay the blame on doctors and patients. They described a doctor who took time off during the terminal illness of his late wife as cutting back on surgery in order to "to smell the roses." A similar attack was made on a doctor who underwent a quadruple heart bypass. The government also described patients seeking to mitigate their pain and suffering as "parasitic." Remarkably, they even claimed that judges of the Supreme Court of Canada in the *Chaoulli* case had been "discredited," citing as evidence various opinion pieces written by opponents.

The BC government justifies existing policy with some outrageous claims and assertions. One such claim is they are in pursuit of "equity," ignoring federally funded CIHI data that show low income groups have the worst access and worst outcomes in Canada. They ignore the exempted groups and their own personal and hypocritical use of private care.

Continued on page 12

Online research tools

When you find yourself asking, "Is that mood disorder a seasonal mood disorder?" or "How long should I continue pharmacotherapy for seasonal affective disorder?" there are tools available to help. The differential diagnosis and treatment of mood disorders can be aided by several types of evidence-based resources, many of which you can download onto your smart phone from the College Library and slip into your pocket.

This article is the opinion of the Library of the College of Physicians and Surgeons of BC and has not been peer reviewed by the BCMJ *Editorial Board.*

If you want to find information from one place, then you may look to resources such as DynaMed and BMJ Best Practice. Both platforms provide information about etiology and epidemiology along with diagnosis and management, all of which can be navigated through clearly laid out menus. Diagnostic criteria include differentials with quick access to additional information. If you aren't sure that you're looking at seasonal affective disorder, you can click over to the depression or bipolar disorder entries for a broader view. As for treatment information, DynaMed offers summaries of the evidence for each treatment, while Best Practice takes a different approach with a streamlined treatment algorithm.

If you want information on bright light therapy, Clinical Key may be of use. The app offers journal articles and abstracts while the web page contains patient handouts and clinical overviews. The *Clinical Handbook of Psychotropic Drugs Online* also offers information on bright light therapy, from definition to dosage.

If you are looking for treatment guidelines for depression, Clinical Key will also give you access to those. Closer to home, BC Guidelines has a guideline app.

For access to these resources and additional information, visit www.cpsbc.ca/library/search-materials/point-of-care-drug-tools. ■

—Chris Vriesema-Magnuson
Librarian

LETTERS TO THE EDITOR

Continued from page 11

Authors reply

The authors acknowledge that the current public health crisis—the opioid epidemic—is complex and multifactorial, and that prescribing patterns are not the only factors, but that they do represent one aspect of the opioid crisis.[1] The authors outlined some descriptive epidemiology of the current public health crisis of opioid overdose deaths, understanding that the current epidemiology itself is complex and that the response to the epidemic requires a multifaceted approach. Acknowledging that medical literature supports that long-term use of opioids typically yields few long-term improvements in pain and function,[2] the article aimed to introduce multimodal approaches for patients with work-related or non-work-related chronic noncancer pain, to introduce the WorkSafeBC physician hotline for community prescribers (who manage patients with chronic noncancer pain), and to inform community physicians of a teaching module developed by WorkSafeBC that delivers educational outreach to community physicians in supporting their patients with chronic noncancer pain. These evidence-based educational modules available to community physicians, pharmacists, nurse practitioners, and other health care providers provide an evidence-based multimodal approach to pain management for patients and cover both the pharmacologic and nonpharmacologic treatments, the educational materials, and the current College standards on opioid prescribing.[3]

—Peter Rothfels, MD
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—Olivia Sampson, MD, CCFP, MPH, FRCPC, ABPM
WorkSafeBC Manager of Clinical Services

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EDITORIALS

Continued from page 5

Supporters of the status quo attempt the fearmongering strategy of citing a US-style system as the inevitable outcome. They disregard the experience in other universal systems, where a little private sector competition often combined with wait-time guarantees results in vastly superior access and outcomes. Following the *Chaoulli* case, Quebec was pressured to create care guarantees. The US bogeyman scenario did not happen.

A CMA poll after *Chaoulli* showed a significant majority of the public, and 83% of physicians, supported the outcome. A 2018 Ipsos poll (mirroring a similar poll in 2012) showed that three of every four Canadians support our litigation. In BC, we have 80% support. When a government spends an estimated $60 million plus in legal costs in an effort to oppose the will of 80% of its people, it makes one wonder what kind of democracy we live in. ■

—Brian Day, MB

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