Letters to the editor

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Breath of fresh air

Some major medical journals are now presenting obvious social and humanities concepts in stupefying detail, so the October 2019 issue of the *BCMJ* was a breath of fresh air. An osteopath friend once told me that one of the three differences between them and MDs was that they had a bedside manner. However, and in spite of the destructive one-problem-per-visit MSP rule, the humorous and ironic editorial, "The secret to Icelandic health and happiness" as well as "Transitions" and "Healthy aging" assure me there are still many docs in BC who put patients at ease and gain their confidence whatever the clinical circumstance.

On the other hand, the conclusions of "Commonly used antibiotics may lead to heart problems" are questionable and the reported findings almost certainly occurred by data-trolling chance. How could current and recent use of fluoroquinolones cause aortic and mitral valves to leak but there is no damage in patients who were previously treated with them?

—G. Frank O. Tyers, MD, FRCSC, FACS, FACC, ABS, ABTS
Vancouver

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Chaos in primary care

As all family physicians in BC can attest, we are living in a swamp of chaos in primary care. My patients can go to any clinic, real or virtual, for care. I am expected to receive third-hand information and incorporate it into the patient's chart with no financial remuneration. Any other provider can order tests and they may or may not be sent to me. If I receive them, I am expected to store the information and act on it if needed with no financial remuneration. Pharmacies can request repeat prescriptions of me without me seeing my patients. These same pharmacies are paid to review and fax requests to me and I receive nothing for my part in renewing these drugs. Insurance companies inundate me with requests for completion of ridiculously complex forms concerning my patients. Patients themselves can come to see me with two-page-long lists of concerns and expect to have them all handled in a 15-minute office visit.

As this situation evolves, it is apparent that I, as the primary provider for a specific patient, am burdened with increasing responsibilities for my patient and diminished financial resources to carry them out. This is the main reason why family medicine is in its death throes. Yes, it is all about money. If I am not deemed to be valuable to society, then why should I participate in the system? This question has been answered by the dearth of new family physicians willing to take on the traditional role of provider in our society.

We have played this game with governments for 40 years and now the jig is up, so to speak. When I retire, my 1850 patients will have nowhere to go because I will certainly not find a replacement for myself unless there is a drastic change to how I am paid. I have written to the *BCMJ* in the past outlining this very point but will now reiterate the message.

If I am to be the primary provider for a patient, then I deserve to get an annual fee or stipend specifically for this task. This fee must be great enough for me to be incentivized to actually take on the role of organizer and main health provider for my patient. Also, if I am the main primary care provider for my patient, then it is my patient's duty to see *me* and not an anonymous provider for their primary care. If they choose to use another provider, then MSP should not pay for this privilege.

If I am this designated and remunerated provider, then it is my duty to be organized into a provider group that can guarantee 24/7 access to primary care for my patient. I have outlined this arrangement of designated provider working within a group and offering 24/7 primary care in articles I have written, published in the *BCMJ*.

This idea still does not have any traction in the new primary care networks (PCN) being pushed out the door by the Ministry of Health. This is why the new networks will fail. Let me be clear: these new networks will fail because they do not give this dedicated money to the specified providers as outlined above. A lot of money is being spent to develop these networks, but since it is not going to benefit primary providers the networks will not, in my opinion, get the necessary uptake by primary providers.

I recently hired a lawyer in Vancouver for some professional work. He did a good job and charged me $425/hour for his services. Just think what life would be like for family physicians if we were remunerated at this rate! It is what we deserve, but governments have beat on us for so long that we actually believe we are not worth very much.

I was involved in our PCN development on South Vancouver Island until it became evident that the ministry wanted family physicians to lead and organize medical homes for their patients and not be remunerated for their efforts. My suggestion was that participating physicians should receive an annual capitated stipend for participation based on their individual patient panels. I had worked this out to be $62 a year per patient. This would mean that if a physician had 1000 patients, that physician would be paid $62 000 year to be part of the PCN.

Even this amount would not really compensate for the added work that family physicians do, but it would be a start. This was rejected out of hand by the ministry. This amount would have almost put BC family physicians on par with Alberta, but still a long way behind those in Ontario. So, good luck to all the people who want to improve primary care. Babylon Health, pot clinics, and Copeman Healthcare Centres beckon. There is always an alternative to the suicide of family medicine as it presently exists in BC.

—Robert H. Brown, MD, CCFP
Sidney, BC

GPSC replies

In his letter, Dr Brown makes some valid points. Family practice is facing many challenges. But is it in its death throes? In my opinion, the answer is no. The value of primary care as laying the foundation for efficient, effective, and sustainable health care is well supported by evidence and is now being acknowledged broadly by government policymakers, health care administrators, and our medical associations as we plan for the future.

The reality is that change, which is often messy, is needed. That is where we find ourselves now. We are in a period of significant change not seen for decades, and it can feel chaotic. But I believe that it will lead to a primary care system that better supports family doctors and the teams that work with them to better meet the needs of the patients we serve. I would like to provide some perspective on some of the issues and what is currently happening.

First, we know that family doctors are frustrated by mounting demands and system challenges that affect our ability to work in an efficient and healthy way to deliver quality care. Doctors of BC members identified these as among the most significant contributors to physician burdens in a consultation conducted last year.

A key issue, as Dr Brown points out, is compensation: many of the things that family physicians do in support of the longitudinal care of their patients are not well supported by the current fee-for-service payment model. In response to this, the General Practice Services Committee (GPSC), a partnership of Doctors of BC and the BC government, has over the years introduced various incentives to help support family doctors in the chronic and complex care of their patients. While this has been valuable, the increase in coordination needed to deal with the large amounts of information, increased complexity in the system, and the aging population means that it is not enough. The recent introduction of the new GPSC Community Longitudinal Care Payment for fee-for-service family physicians is one step toward recognizing this.

Beyond various incentives or payments, moving away from fee-for-service to other methods of compensation is an option now desired by many physicians. A consultation process currently underway between the Ministry of Health and Doctors of BC is actively exploring the development of new compensation models, with the aim of starting to provide these options later this year.

The need for change, however, goes beyond compensation. As Dr Brown notes, physicians need to be supported by a network that enables them to provide patients with appropriate access to comprehensive care as part of their practice. The divisions of family practice, developed and supported by the GPSC, provide physician support and connections at the local level that set the foundation for this networking and for broader system partnership and planning.

Change is inevitable, and physicians are being enabled and empowered to have a significant voice in creating and leading this change. The collaborative tables set out through the Physician Master Agreement provide the opportunity for this influence. The GSPC is the leading collaborative table for primary health care transformation in BC, supporting the creation of patient medical homes and the implementation of primary care networks enabled by team-based care.

The patient medical home—the cornerstone of primary care networks—describes an ideal family practice where the physician is supported by a team of providers to provide longitudinal quality care to a defined population of patients. With the support of a team, a family doctor will be freed up to appropriately address concerns that require a physician's expertise. To support family practices to shift to team-based care in patient medical homes, the GPSC is providing in-practice coaching and supports, incentives, and technology supports.

Through primary care networks, divisions of family practice—representing physicians and practices/patient medical homes—are partnering with health authorities, First Nations, and community partners to bring health care providers together into clinical teams, to wrap services around doctors and their patients, and to collectively meet the primary care needs of their communities.

Across the province, hundreds of physicians are participating in and leading primary care change at the practice, community, and provincial levels. I believe we have the right people at the right tables to work through the challenging conversations that need to happen to ensure that the changes we make result in a more fulfilling and rewarding professional practice for physicians and the teams that work with them, make better use of system resources, and ultimately provide better care for the patients that we all serve.

The issues are real. Change is messy and it takes time. But with this level of talent, strength, and leadership among our physicians, I believe we are stepping forward together into a brighter future.

—Shelley Ross, MD
Co-chair, General Practice Services Committee

Re: Influence of breast density on breast cancer diagnosis

The authors are to be applauded for performing this study [*BCMJ* 2019;61:376-384]. They have listed some of the limitations in their methodology (Study challenges), but there are others pertinent to their conclusions.

Objective 2 was to assess the stability of BI-RADS density categories assigned to screening participants. They used a subset of the mammograms of participants age 40 to 74 obtained in 2017 using digital mammography and compared them with earlier mammograms. Density may diminish during the menopause transition.[1] They apparently did not ensure that the two examinations were either both done premenopausally or postmenopausally. This could introduce further discordance and exaggerate the calculated instability of the density assessment. Similarly, hormone therapy can increase density.[2,3] They apparently did not make efforts to avoid comparing examinations while on, and subsequent to, discontinuing hormone therapy, so additional discordance could result. The information on hormone use is collected at the time of the screening appointment, but the authors did not take this into account.

Objective 3 was to examine the influence of density on the risk of breast cancer. They included mammograms performed from 2011 to 2015, but they excluded screening rounds that followed an abnormal result. It has been shown that women with a history of a false-positive mammogram result may be at increased risk of developing breast cancer for up to 10 years after the false-positive result.[4-8] By excluding screening rounds that followed an abnormal result from the analysis, they may have underestimated the influence on breast cancer risk.

They aimed to estimate rates for screen-detected and interval cancer for participants at average risk and higher-than-average risk. But the BC Cancer Breast Screening Program (BC-CBSP) limits "increased risk" only to women with a first degree family history of breast cancer.[9] It is known that women who use hormone therapy are at increased risk,[3] as are women with dense breasts.[10-12] By not acknowledging these additional risks, and including them with average risk women, the authors may have underestimated the true difference in risk between average- and higher-than-average-risk women. This may explain why there wasn't a greater difference in the interval cancer rates and why they did not show greater nodal involvement in the interval cancers.

So it may not be true that, as the authors state, "Following a normal screening mammogram, a screening participant's risk of being diagnosed with an interval breast cancer over the next screening round . . . is roughly similar at 1 year for women at elevated risk to that at 2 years for women at non-elevated risk."

Even with these limitations, they still showed that tumors in screen-detected cancers were smaller than in interval cancers and less likely to have nodal involvement, and that within the screen-detected cancers, tumor size increased with increasing density.

The authors state that, "Current Canadian breast screening recommendations do not indicate further breast screening in addition to routine mammography," but these are based on the 2018 guidelines from the Canadian Task Force on Preventive Health Care.[13] This is a committee that excludes experts funded by the federal Minister of Health through the Public Health Agency of Canada. When challenged in question period by the NDP health critic, both the Minister of Health and her parliamentary secretary insisted that, "These are not

government guidelines." And indeed, BCCBSP does not follow them to the letter.[14]

In discussions with patients, family physicians should be aware that the Task Force limited their review to randomized controlled trials performed from the 1960s to the early 1990s that studied only mortality reduction as a benefit to screening. They ignored metrics on reduced morbidity, which are of considerable importance to women—fewer mastectomies, fewer axillary dissections and resulting lymphedema, and less need for chemotherapy when cancers are detected early during screening.[15-18]

This is also the case with the US Preventive Services Task Force, which considers evidence to be insufficient to recommend any adjunctive screening on the basis of breast density alone,[19] and yet 39 states now inform women of their breast density and the FDA has introduced legislation that, when passed, will require all women to be informed.[20] And many states offer supplemental screening covered by health insurance. In Connecticut, where legislation was passed in 2009, practices have been detecting three to four additional cancers missed on mammograms per thousand average-risk women with BI-RADS C and D densities.[21] This constitutes a doubling of the cancer detection rate in dense breasts; cancers that would have presented later as interval cancers with worse prognostic characteristics if undetected. Austria, France, and one state in Australia include supplemental screening ultrasound for women with dense breasts in their screening programs. Reduction of interval cancers as seen in the Japan Strategic Anti-cancer Randomized Trial (J-START),[22] is a prerequisite of reduced mortality. So to insist on waiting for results of this trial, and say that there is no evidence to support supplemental screening, is misleading.

Yes, there are false positives associated with initiation of screening ultrasound, but these diminish with subsequent screening rounds. And the associated biopsies may cause inconvenience, but they are performed as percutaneous needle biopsies with local anesthetic, are well tolerated, and are similar (or less) for most women to the discomfort of a venipuncture: a small price to pay for the opportunity of early detection. The decision to have supplemental screening, which is now an insured service in British Columbia, should be made with shared decision making between a women and her physician, with all the information above.

—Paula B. Gordon, OBC, MD, FRCPC, FSBI
Vancouver

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Authors reply

The authors would like to thank Dr Paula Gordon for her time and thought in reviewing our article and for providing valuable feedback for consideration. We agree that changes in menopausal status and hormone therapy use are known to affect assessed breast density, and physicians should consider these potential influences for patients with varying assessed density. Nevertheless, sequential variation in BI-RADS assessed density may have no apparent cause, and this is an attribute of current density assessment.

While our results were concordant with the previously reported phenomenon of population average breast density decreasing with age,[1] it is correct that we did not investigate the possibility of a concurrent influence of menopause. The observed distribution of breast density by age (Figure 3 in our article) does not confirm an aberration in the trend for each density category, but as indicated menopause may have been a factor.

Regarding a possible influence of hormone therapy, of the 62 887 mammogram pairs eligible for the determination of the stability of

reported breast density, reported usage ("no" or "yes") was stable in 59 181, or 94%. This was unlikely, then, to have had a significant role in density assessment.

The reported relative risk of breast cancer for combined estrogen and progestin ranges from 1.3 to 2.0 for 5+ and 10+ years of usage respectively.[2,3] The available program data for hormone use were limited to self-reporting of current use only. It would have, therefore, been difficult to acquire reliable measures for the duration of usage, and this limitation was thus unavoidable. We do note that just under 10% of the cohort analyzed for breast cancer risk reported current hormone usage.

Currently our screening guidelines divide age-eligible women into two groups for mammography screening: average risk and higher-than-average risk (first-degree family history). We agree with Dr Gordon that within each group other factors influence an individual woman's risk of breast cancer, but we used the existing determinants of screening frequency to present our findings.

We agree that a previous false positive screen has been shown to increase breast cancer risk. This has been demonstrated externally,[4] and also by a review of over 4 million mammograms of our provincial program from 1988–2013, which demonstrated a relative risk of 1.73 after an initial false positive.[5] In clarification of our methodology, please note that such cases were *not* necessarily excluded from our analysis. The inclusion criteria of a screening round included that it began with a negative screen, but the individual may have had a false positive in the past. This was done in recognition of the further testing that these individuals would have undergone and to minimize the possibility of subsequent screening mammography performance being influenced by factors other than breast density. Our results may thus be best suited for facilitating discussion with screening participants whose most recent screen was normal, but who may have had a prior abnormal screen.

The primary aim of population breast screening is to reduce the risk of death from breast cancer among BC women. While we concur that a decrease in interval cancer is likely a requisite of reduced mortality, we also note that it does not guarantee a reduction. Reduced risk of breast cancer death is most reliably indicated by reductions in the rate of advanced cancer at diagnosis. In considering the effect of screening on advanced cancer, it is important to consider both screen-detected and interval cancers as a whole, not just those cancers detected at screening: one extra early stage screen-detected cancer does not necessarily translate into one less advanced interval cancer. We would like to clarify that we have not stated that "there is no evidence to support supplemental screening," as Dr Gordon writes in her letter. Indeed we have cited the same Japanese trial,[6] and agree that a decrease in interval cancers has been demonstrated for supplemental ultrasound in this randomized study. However, the first round of this trial, which compared mammography alone to mammography plus ultrasound, found that the addition of ultrasound resulted in a further detection (by ultrasound alone) of 61 cases of breast cancer of which 48 were early (9 stage 0 cases, and 39 stage I cases), but a reduction of only one case of stage II or worse interval cancer.

We have also referenced a meta-analysis of supplemental ultrasound[7] in order to report the increased cancer detection of this test, but we disagree that these additional cancers would necessarily present as interval cancers. The increased detection observed in the randomized trial, for example, exceeds the decrease in interval cancers.[6] The difference could include additional subsequent interval cancers, but the balance with cancers that would be detected at the next mammography screen and overdiagnosis has yet to be determined.

The authors completely agree that shared and informed decision making be facilitated as best possible, and this was a key objective of our article. Again, we are thankful to Dr Gordon for sharing her insight and for this discussion of such an important topic in breast health.

—Colin Mar, MD, FRCPC
Medical Director, BC Cancer Breast Screening Program
On behalf of all authors

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Re: WorkSafeBC's multimodal approach to chronic noncancer pain management

WorkSafeBC appears to conclude that opioids are not useful for injured workers unless they help people get back to work. This article [*BCMJ* 2019;61:176,179] contains insufficient information in making conclusions about the use of opioids to help injured workers with chronic noncancer pain return to work. Patients in this group may not be able to return to work but may sleep better, have improved mood, and have better family relationships with proper pain control. The article is also missing key information about the nature of the injuries incurred by these workers (e.g., severe electrical event, loss of limb, severe back injury, head injury). It is true that the use of opioid analgesics for chronic pain is a last resort, following treatment with rehabilitation therapy, acupuncture, etc., in all but extreme cases. Physicians are not to blame for the appalling epidemic of deaths due to street fentanyl. The current restrictions arising from the epidemic have left many patients in a painful limbo, which may lead many of them to turn to these same dangerous street drugs.

—Helen Hays, MD, CCFP, FCFP
Black Creek

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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

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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
WorkSafeBC Chief Medical Officer and Director of Clinical Services

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

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EDITORIALS

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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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