Letters to the editor

We welcome original letters of less than 300 words; we may edit them 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. Please disclose any competing interests.

Re: Evidence-based opioid sparing approaches to pain management

We would like to express our concern regarding the article "Think twice: Evidence-based opioid sparing approaches to pain management."[1] We share the authors' concern with the current increasing death toll from poisoning of the illicit drug supply and the desire to minimize the harms from prescribed opioids. We are fearful, however, that this article will have unintended consequences for people who *should* be receiving opioid-based therapy.

Despite the abstract specifying that the suggestions were not directed at cancer pain, we have learned from experience that this important distinction is often unappreciated by readers. It is important not to just briefly mention this population in passing, but to be very clear that the suggestions offered in the article *do not apply* to a significant number of people. The figure in the article is titled only "acute and chronic pain" and doesn't specify what group it is intended for. The title also is not specific. The authors and the *British Columbia Medical Journal* are only a few of many who have allowed this oversight, but it needs to stop.

We and many colleagues in palliative care and oncology are seeing more and more patients with cancer pain who are being stigmatized in their search for a primary care provider and being refused opioid prescriptions by their established family doctor. Pain is prevalent in 30% to 50% of people who receive cancer-directed treatments and over 70% of people with advanced cancer.[2] Opioids remain the treatment of choice for moderate to severe cancer pain.[3] It was reported that the morphine equivalent daily dose (MEDD) prescribed by oncologists before referral to palliative care decreased between 2010 and 2015 to 40 mg from 78 mg at the MD Anderson Cancer Center in Texas.[4] We feel the same is happening here in BC.

The Canadian Institute for Health Information was pleased to announce in 2019 that there had been a steady decline in the proportion of people over 65 who were started on opioids from 2013 to 2018, as well as in the proportion on long-term opioid therapy.[5] Considering the growing numbers in this age group due to our aging population, the drop in opioid prescribing in older adults is concerning. Chronic, disabling pain is more common in older adults and increasing comorbidities increases the prevalence of pain. The American Geriatrics Society, in its publication *2020 Geriatrics at Your Fingertips*, still recommends opioids for persistent "moderate to severe pain (6–10), and pain not alleviated by non-opioid therapies that is severe enough to impact function and quality of life."[6] Frail seniors, particularly those in long-term care, are not a demographic that has experienced serious harms from poisoning of the illicit supply, yet they also have had significant reductions in access to opioid-based analgesia.

We believe that messaging about opioids needs to be balanced and urge colleagues who see only the dark side of opioids to more clearly define situations to which the available evidence applies. Regarding publication style, headings are important, as sometimes they are the only parts of an article that are read. Images (such as the figure in the article) should not sacrifice subtlety in favor of simplification.

The two sides of opioids—reliever of pain and dyspnea and demon of addiction—will never be eliminated, but opioids would be used less with access to evidence-based nonpharmacological treatments that are funded as adequately as medications so that physicians have more to offer their pain patients, no matter what kind of pain they have. One hopes that any future provincial or national pain strategy mandates the funding for these therapies.

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

—Philipa Hawley, BMed, FRCPC

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Re: Anti-Black racism in medicine

Dr Dixon's essay in the July 2020 issue of the *BCMJ*[1] is a powerful reminder of our need to consistently reflect on our positionality in the field of medicine and, more importantly, as part of our overall moral compass. The challenges she discusses both as a Black physician and through witnessing the care of Black women in the Canadian health care system cannot be tolerated.

A key point is the critical need for more Black physicians, so that Black patients feel that their physicians represent them and can understand their unique cultural values and

Continued on page 317

Anti-Black racism *Continued from page 315*

experiences.[1] Recent research[2] highlights the enormous benefits of patient-physician concordance on health care outcomes for minority populations and shows that it can reduce widely held biases, boost effective communication, and increase trust. More importantly, this research found that when Black physicians cared for Black newborns, the newborn mortality rate can be reduced by half.[2]

While creating greater support for Black students to enter medical school is just a small part of our collective battle against racism, it is a clear step in the right direction. Thus, medical schools in Canada have a responsibility to ensure that Black students have the best opportunity to matriculate and be successful in medicine. It is important to recognize that the lack of equitable representation among medical trainees is a huge barrier to building an efficient and inclusive health care system in Canada.

We must acknowledge and reflect on previous barriers that have been set up by Canadian medical schools against Black students. An example of a direct barrier in Canadian history is Queen's University's official ban preventing the admission of Black students that was enforced from 1918 to 1965.[3] However, it was not until very recently, in autumn 2018, that this ban was officially revoked.[3] This example provides a sense of the discrimination that Black students have faced and continue to face when entering medical school. Additionally, some of the barriers described in the literature for Black applicants entering medicine include enormous financial difficulties, the complex nature of admissions, and unsupportive advisors.[4] Hence, we can understand that there are plenty of challenges that Black applicants face when applying to medical school. Moreover, evidence[5] from examining the bias of medical school admissions committees shows statistically significant ($p < 0.05$) race bias among admissions committee members favoring White applicants. Long-standing racism, significant barriers, and the bias of admissions committees underscore the need for alternative pathways that minimize negative biases to successfully admit Black students into medical school.

Of the 17 medical schools in Canada, only four have optional entry paths that separate Black medical students from the general stream **[Table]**: the University of Toronto, the University of Western Ontario, the University of Calgary, and the University of Alberta. These separate entry pathways are important to ensure that Black students are evaluated in a holistic manner free from negative biases,[5] as evaluators are composed of Black community members and faculty. It is important for these pathways to be expanded to all 17 Canadian medical schools. Canadian medical schools should take a collaborative approach, developing programs among each other and in consultation with Black applicants, community members, and faculty, so that we can truly listen and support Black applicants in the best way possible. It should be a responsibility of all medical schools in Canada to ensure that they create and consistently evaluate programs that allow Black applicants to become successful in entering medicine.

Alternative entry pathways are important to support Black students matriculate into medical schools. However, we must remind ourselves that these pathways constitute only a small part of our overall approach in dismantling the systemic racism that is present in Canada; it is necessary to bring innovative and forward-thinking solutions to this long-neglected health care disparity. Much larger systems-level changes tackling racism are needed as well.[1]

—Nilanga Aki Bandara, BSc, Vancouver

—Vahid Mehrnoush, MD, Vancouver

—Ricky Jhauj, BKin, Vancouver

TABLE. List of Canadian medical schools and whether or not they have separate entry pathways for Black students.

Canadian medical school	Separate entry path for Black applicants (Yes or No)
University of Alberta	Yes
University of Calgary	Yes
University of British Columbia	No
University of Manitoba	No
University of Newfoundland	No
Dalhousie University	No
McMaster University	No
Northern Ontario	No
Queen's University	No
Western University	Yes
University of Ottawa	No
University of Toronto	Yes
Université Laval	No
McGill University	No
Université de Montréal	No
Université de Sherbrooke	No
University of Saskatchewan	No

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PRESIDENT'S COMMENT

Continued from page 316

of BC. As well, unconscious bias training for members of our governance structures, including the Board, statutory and standing committees, the Joint Collaborative Committees, and the Representative Assembly, will take place over the next year. It is part of our commitment to support greater cultural diversity and inclusion, and our efforts to combat racism and support cultural safety within our membership.

Doctors of BC is collaborating with all of our partners, government, and health authorities, including the First Nations Health Authority, to break down barriers and improve our health care processes. This cannot be done in a vacuum. Only together can we reach our full potential. We will collectively strive to find our similarities, that common ground of humanity and respect that links us together. Only then will we be at our best as a society, and as a profession, best equipped to meet the needs of all our patients. ■

—Kathleen Ross, MD
Doctors of BC President