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.

Interdisciplinary resources when patients want to leave hospital against medical advice

We commend your article "Management of vulnerable adult patients seeking to leave hospital: Understanding and using relevant legislation" [*BCMJ* 2021;63:106-111]. For consultation-liaison psychiatrists, capability assessments may be nuanced when patients have fluctuating lucidity or are under the coercive forces of addiction.

A few comments to supplement this extremely helpful article. Options include consulting the ethics service and risk management for perspectives that uphold nondiscrimination, balance harms and benefits, and respect the capable individual's legal right to live at risk. Hospital social workers can liaise with the Re:Act team, which assesses adults when there is concern about their ability to access support in the community.

You mention the Public Guardian and Trustee (PGT) as a surrogate decision-maker either when there is no temporary substitute decision-maker (TSDM) or when appointed individuals cannot reach consensus. On your Figure, you might add the PGT at the bottom of panel #1, with an additional arrow to PGT after "NO" for emergency and "NO" for TSDM/consensus.

Documenting a second opinion is prudent if there is time before emergency treatment for which consent has not been obtained. For the middle of panel #1, we suggest: "YES" for emergency and "NO" for SDM, then "provide treatment without consent (with second opinion if possible)."

Trainees are benefiting from your superb summary of BC law. An interdisciplinary approach is ideal as there can be significant angst about limiting freedoms and failing to protect those who have lived their entire lives with risks that we ourselves have never taken.

—Stephen D. Anderson, MD, FRCPC
Clinical Professor, Department of Psychiatry, UBC Faculty of Medicine

—Carol P. Anderson, MD
Clinical Instructor, Department of Family Practice, UBC Faculty of Medicine

—Bethan Everett, MBA, PhD
VCH Ethicist, Clinical Professor, UBC Faculty of Medicine

Re: An inside look at BC's illicit drug market

While the case study presented in "An inside look at BC's illicit drug market during the COVID-19 pandemic" [*BCMJ* 2021;63:9-13,19] may provide physicians who have limited knowledge of the illicit drug trade information about substance use, there are multiple problematic depictions of persons who use drugs (PWUD). The images included, a dark silhouette of a hooded figure and a person lying on the sidewalk in front of a graffitied wall, depict stereotype images of substance users, namely that they are troubled, shady, decrepit, and pitiful. The narrative presented further substantiates stigma and stereotypes, conflating substance use with addiction and poverty. John Doe is an almost contextless individual, chosen as the standard of the illicit drug trade, but why, without evidence of consultation or input from other drug user sources? Organizations like the Vancouver Area Network of Drug Users (VANDU) and the Canadian Association of People who Use Drugs (CAPUD) are instrumental in changing stereotypes of PWUD and engaging people with lived experience in the process of research and policy development.

Given that John Doe was incarcerated and undergoing psychiatric assessment at the time of the interview, was consent informed? Further, description was provided that John Doe was admitted to the forensic psychiatric service because of evaluation following conviction for distribution of illegal substances, but what qualified him as a reliable source? Was there a pre-existing relationship between the interviewer and the interviewee? The assumption that his response was coercion-free is problematic because of the nature of the inherent power imbalance. We must question the ethics of asking people who are accessing health care services for more information in an assessment interview as a teaching tool or population insight. Vicarious information collection, potentially traumatizing the individual, may have benefit to the greater good, but does that mean clinicians should engage in this process at risk to the individual?

—Michelle Danda
New Westminster

The images that accompanied the article were chosen by the editorial team, not the authors. Images are open to interpretation, and we appreciate you sending us yours. —Ed.

Authors reply

We appreciate Michelle Danda's letter in response to our case report "An inside look at BC's illicit drug market during the COVID-19 pandemic" [*BCMJ* 2021;63:9-13,19].

We wanted to note that a case report describes and interprets the experiences of a single individual. Therefore, the findings from a case report may intrinsically have limited generalizability, and this was stated in our article. However, the merits of a case report are that it presents novel, informative narratives, generates ideas to be examined in future studies, and serves as a valuable educational tool. Case

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with applications to COVID-19," is available at www.ncbi.nlm.nih.gov/pmc/articles/PMC7995646.

Planning a birth after C-section made simpler

My Next Birth is a personalized online interactive patient decision aid now being used throughout BC to help people who have previously had a C-section make better-informed decisions about navigating their next pregnancy and birth. Over 75% of people in BC who have had a C-section are good candidates for a vaginal birth after cesarean, but families often have to wait until the next pregnancy to start discussing options with their care team. People want to learn about their options for their next birth sooner. Researchers conducted a series of qualitative studies and surveys in BC and found that families and care teams needed more support when exchanging information.[1-4] Families wanted to know what the reasons were for their first C-section. Was it from something unexpected that happened during labor? Is this something that might happen again in the future? What are the options for their next birth?

The program helps them think about their preferences and jot down their questions, and it provides tailored information specific to their values and needs. It also factors in where they live in BC so they can consider what resources are available locally. After they work through the website, they receive a personalized summary to guide conversations and questions with their health care team.

The program also provides tools for health care teams, including a decision support algorithm that walks the care provider through the patient's journey and a list of conversation prompts to guide discussions after a C-section. The hope is that the program can be a support for families to be active participants in their care.

Dr Sarah Munro, an assistant professor in obstetrics and gynecology, developed the program with her team at UBC in partnership with Perinatal Services BC, provincial health authorities, the Ministry of Health, as well as patient partners. For more information, visit www.perinatalservicesbc.ca/health-professionals/professional-resources/birth-after-caesarean.

References

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2. Munro S, Wilcox E, Lambert LK, et al. A survey of health care practitioners' attitudes toward shared decision-making for choice of next birth after cesarean. Birth Issues in Perinatal Care 2021;48:194-208.
3. Munro S, Janssen P, Corbett K, et al. Seeking control in the midst of uncertainty: Women's experiences of choosing mode of birth after caesarean. Women and Birth 2017;30:129-136.
4. Munro S, Kornelsen J, Corbett K, et al. Do women have a choice? Care providers' and decision makers' perspectives on barriers to access of health services for birth after a previous cesarean. 2017;44:153-160.

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reports are the substrate from which larger, more generalizable studies can be justified. Some of the information may have not been new to people who work extensively in the field of addictions. However, the article was published in a general medical journal for physicians who may not have extensive experience in the field. By engaging with a person with lived experience, we were able to share his unique experiences and perspectives, which may inform areas of future research and strategies to improve health care for vulnerable populations.

We used the name "John Doe" to protect the identity of the individual. We had the information to provide much more context, but given the word count limitations of the article, the need to protect John Doe's identity, and the fact that we were publishing in a general medical journal, we focused on reporting his observations and opinions of the illicit drug trade rather than more personal characteristics.

As for what qualified John Doe as a reliable source, he was convicted in a court of law for distribution of crystal methamphetamine and fentanyl in the Downtown Eastside during the COVID-19 pandemic. Since this was the topic of the case report, we believe that qualified him to speak about the topic. His account was consistent with external data points, such as court records and collateral sources, where available. Further, there are many examples of the experience of people who use drugs in the medical literature but very few examples of people who sell drugs. The goal of the article was to highlight the lived experience of someone who sold drugs, not people who use drugs, during a unique time in history such as the COVID-19 pandemic.

There was no pre-existing relationship between the physician interviewer and John Doe. In a forensic evaluation, the forensic psychiatrist is to maintain neutrality and objectivity in their assessment of all patients. The forensic evaluation is done voluntarily, and before the evaluation can begin, it must be determined that the patient has the capacity to consent. During the forensic evaluation, John Doe raised the topic of illicit drug trade in the Downtown Eastside during the COVID-19 pandemic. He was then asked whether he wanted to share his insights for a case report. His participation was completely voluntary, and he was assessed to have the capacity to consent to the case report. As reported in our article, written informed consent was obtained from him. He voluntarily agreed to share his information because, in his words, "I want to provide information that hopefully can prevent overdoses and save someone's life. I think it'll be useful for the medical community."

—Nickie Mathew, MD, MSc, ABPN, FRCPC, ABPM

—James S.H. Wong, BSc

—Reinhard M. Krausz, MD, PhD, FRCPC