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: Impact of school closures on learning, and child and family well-being

Thank you for this article [*BCMJ* 2020;62:338]. It is most interesting and highlights the importance of in-person education for our children. I raise only one point—are we forgetting about our teachers? Are they being put in a precarious position without the appropriate protections, consideration, autonomy, and appreciation? This remains my bias. The article suggests low risk on the assumption that preventive measures can be taken. Dr Bonnie Henry has suggested in a statement that "teachers know best [how to stay safe] in their classroom." My assertion, though purely anecdotal, is that we are asking too much of our teachers without providing sufficient checks and balances to ensure that they remain safe. Who will be their voice when they feel unsafe? How can they efficiently and appropriately enact policy change to protect themselves and their families? Administrators vary with respect to ability to address necessary concerns. Social distancing, it would seem, is next to impossible to achieve. Teachers seem effectively neutered when it comes to implementing mask policies, and I suspect are confused as to why the policy should vary from a child in their classroom to the same child in a grocery store. I have often found myself counseling parents who are struggling personally that to most effectively care for their child (our patient), they too must take care of themselves. Should we not, as a community, be advocating the same for our teachers? If they feel afraid, unsupported, burned out, or unsafe, how can we expect them to take on the enormous responsibility of supporting, educating, and nurturing our children? Thank you.

—James Harris, MD, FRCPC
Vancouver

Re: Peer reviewers, editors, experts, and statisticians—do we need them?

I would like to congratulate Dr Brian Day on his editorial in the October issue of the journal [*BCMJ* 2020;62:266]. It clearly lays out a problem that has dogged the medical and scientific community for years. I am sure a vast amount of valuable research has been lost through the years by way of this tedious process, not to mention the discouragement of young researchers. I would be interested in his views, and those of any other readers on the phenomenon of preprints, particularly medRxiv. A paper on this subject was recently published by *JAMA* (https://jamanetwork.com/journals/jama/article-abstract/2772749, login required).

I believe that this new method of publishing will speed up exponentially the communication of scientific and medical information as well as give instant feedback and encouragement to researchers. It in no way impedes the traditional publishing method, which can continue in the old way, albeit at a glacial pace.

—A.F. Shearer, MD
Surrey

Re: Opioid prescribing

The letter about appropriate access to opioid-based analgesia from Drs Gallagher and Hawley [*BCMJ* 2020;62:315] notes the steady decline in the proportion of people over 65 being started on opioids and the harm that such a reduction has for seniors. Mention is made of patients' regular physicians refusing to prescribe opioids, along with the unlikelihood of seniors having problems with addiction after being started appropriately on opioids, and the consequent irrelevance of concerns about the toxicity of preparations that might be obtained from the illicit drug market.

As a senior and a retired family practitioner, I have personally noted the reluctance of younger physicians to prescribe codeine-containing preparations, and I have heard the suggestion that a drug contract should be signed before doing so. The impression has been gained that a push toward not prescribing takes precedence over attention to alleviation of symptoms. When a prescription is granted, only a small number of tablets are given.

What is actually going on to produce these putative manifestations? My feeling is that primary care physicians are under the impression that their licence to practise is in jeopardy if they prescribe opioids, and that such acts place them under increased scrutiny from licensing authorities. This leads to a reluctance to prescribe opiates and to undue weight being placed on resisting requests for opioids, however appropriate such prescribing might be.

If my impression is correct with regard to opioid prescription, then physicians, licensing authorities, and regulatory bodies need to get together and move the pendulum back toward concern for appropriate patient care and away from the fear of retribution.

—Anthony Walter, BA, MB BCH
Surrey

Re: Physicians suffer infertility too

I wanted to thank you for shining a light on the darkness of infertility, which affects 12% to 15% of couples in Canada.[1] Physicians are disproportionately affected, as highlighted by Dr Dunne's editorial.[2] In addition to the financial burdens of infertility treatment, infertility among female physicians can cause myriad downstream effects, including increased burnout; mental health effects[3] with depression and anxiety rates similar to those in people with cancer; and feelings of regret, sadness, and shame over career decisions made while family planning.[4]

I am a physician in BC and have undergone multiple treatments for infertility. I know firsthand the grief and hardship that come from a multiyear struggle with infertility. I am happy to report that since my previous correspondence several years ago,[5] I have had successful treatment. Unfortunately, despite multiple

letters, I have not been successful in convincing the BC Ministry of Health to cover infertility treatments so that others with lesser financial means can receive the same opportunities for treatment. This is despite the Ministry of Health's first expressed mandate being "to make life more affordable. Too many families were left behind for too long."[6] Many infertile patients in BC continue to struggle to afford the high costs of treatment, which is not covered by MSP. Those without the financial means to undergo treatment when medically indicated may spend years saving resources, only to have their chances of success decline in those intervening years. It is time that BC stops making excuses and define infertility as a disease, as recommended by WHO,[7] worthy of care under the universal health coverage that we Canadians are so proud of.

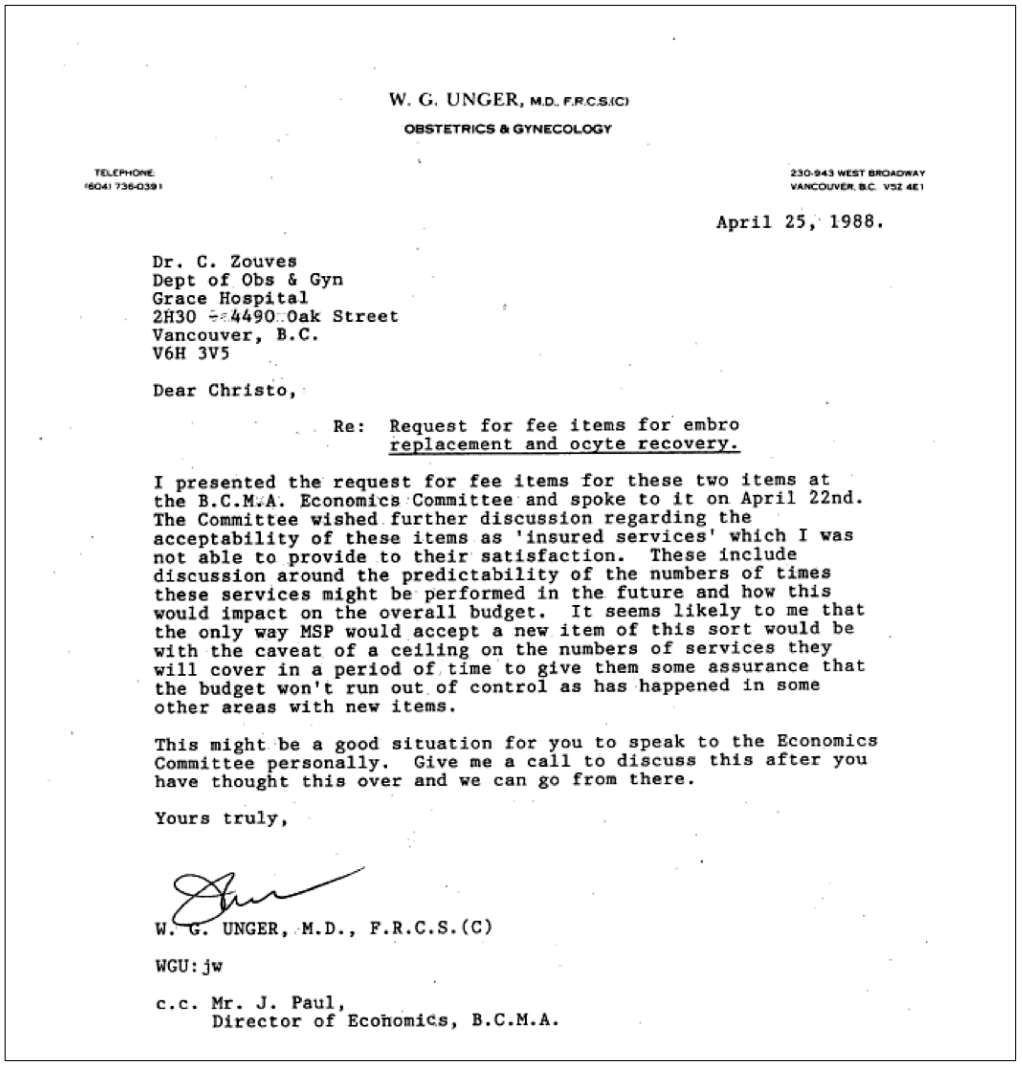
One of the responses I received from the Ministry of Health was that "MSP relies on the advice of the medical profession in determining the medical necessity of procedures. To date, there has been no indication from the medical profession that it considers IVF to be medically necessary." Interestingly, one of my obstetrician-gynecologist colleagues was able to determine, that in fact, the Obstetrics and Gynecology Section of Doctors of BC has been advocating for coverage for over 30 years, as shown in a letter from 1988 **[Box]**. How long do physicians need to make a request before it is considered? Surely 30 years is too long.

Unlike some other diseases, infertility lacks a vigorous, well-funded advocacy group.[8] The reasons are multifactorial, although one could speculate that financial depletion, emotional exhaustion, and stigma may contribute. At any rate, the infertile population would benefit from more physicians speaking up for them, so I thank the *BCMJ* and Dr Dunne for doing just this.

To support physicians struggling with infertility, I have written several requests to the Doctors of BC Health Benefits Trust Fund to stop singling out infertile patients for exclusion of coverage. Currently, infertility is the only disease category with a lifetime maximum for medication coverage (limited to $2400, which may not even cover medications for one IVF cycle). Removing this lifetime maximum would be a small but meaningful step toward demonstrating that physicians of BC are supporting each other in the face of infertility.

Thank you again for bringing attention to this heart-wrenching yet common problem that British Columbians face. I wish all those struggling with infertility the very best with achieving their family goals, but most of all, I hope they will be treated fairly and compassionately by their physicians and our health care system.

—Susan M. Lee, MD, FRCPC, MAS
Assistant Clinical Professor, UBC



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April 25, 1988.

Dr. C. Zouves
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Dear Christo,

Re: Request for fee items for embro replacement and ocyte recovery.

I presented the request for fee items for these two items at the B.C.M.A. Economics Committee and spoke to it on April 22nd. The Committee wished further discussion regarding the acceptability of these items as 'insured services' which I was not able to provide to their satisfaction. These include discussion around the predictability of the numbers of times these services might be performed in the future and how this would impact on the overall budget. It seems likely to me that the only way MSP would accept a new item of this sort would be with the caveat of a ceiling on the numbers of services they will cover in a period of time to give them some assurance that the budget won't run out of control as has happened in some other areas with new items.

This might be a good situation for you to speak to the Economics Committee personally. Give me a call to discuss this after you have thought this over and we can go from there.

Yours truly,

W. G. UNGER, M.D., F.R.C.S.(C)

WGU:jw

c.c. Mr. J. Paul,
Director of Economics, B.C.M.A.

The Obstetrics and Gynecology Section of Doctors of BC has been advocating for coverage for over 30 years, as shown in a letter from 1988. This letter reproduced with permission.

References

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8. Adashi EY, Dean LA. Access to and use of infertility services in the United States: Framing the challenges. Fertil Steril 2016;105:1113-1118.