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: Unnecessary musculoskeletal MRIs

I read with interest the letter to the editor by Dr Kostas Panagiotopoulos in the November 2021 issue of the *BCMJ*. I would like to add another suggestion to save time, money, and resources. For 8 years I was director of St. Paul's F.A.S.T. Clinic (Foot and Ankle Screening and Triage). I also provide lower extremity virtual consultation for GPs in BC for their patients with orthopaedic problems through The RACE Line (Rapid Access for Consultative Expertise). In most cases, imaging has already been obtained before I am consulted. For foot and ankle problems, it is often essential and critical for these issues to be evaluated with weight-bearing radiographs. Unfortunately, most preliminary imaging is done without weight-bearing stress by default. This makes many common conditions such as Lisfranc's fracture dislocation and syndesmosis disruption accompanying ankle injuries very difficult to diagnose. The lack of appropriate imaging also necessitates additional imaging with its additional burden on resources and cost, not to mention the inconvenience to the patient to go back for more X-rays. I strongly recommend to GPs in BC that all foot and ankle radiographs be requested with weight-bearing views unless the severity of the trauma or pain precludes standing imaging.

—Jeffrey L. Nacht, MD
Vancouver
Clinical Professor of Orthopaedic Surgery, UBC Faculty of Medicine

Comment from Dr Brian Day: Dr Nacht makes a valid point that I wholeheartedly support. I would simply add that, when possible, weight-bearing views should also be performed in the assessment of hip and knee joint pathology, especially when there is a possibility that a procedural intervention may be required. As Dr Nacht points out with the foot and ankle, acute trauma where a fracture may be present are exceptions.

Re: Unnecessary musculoskeletal MRIs

Dr Panagiotopoulos raised the issue of unnecessary musculoskeletal MRIs in the November 2021 issue of the *BCMJ*. This problem of unnecessary imaging studies is not isolated to MRIs. I can corroborate his experience with receiving referrals that are frequently accompanied by unnecessary and clinically unhelpful MRIs and, indeed, other advanced imaging studies (nuclear medicine scans, ultrasounds, CTs, etc.). These studies can at times also be harmful by delaying referral and creating unnecessary patient anxiety through misleading interpretations.

Causative factors appear to include (1) misguided patient demand, (2) a lack of knowledge of indications for advanced imaging on the part of the ordering clinicians, (3) an absence of appropriateness screening by radiology, and (4) the frequent suggestion by radiology to perform advanced imaging that is clinically unhelpful and that primary care clinicians feel obliged to order.

With high demand and long waits, the response from governments and some health authorities was to increase the number of MRI scanners and their hours of use rather than to focus on appropriate use. This has led to a worsening of the problem. In the Northern Health Authority (NHA), between 2018 and 2019 this policy led to an 86.9% increase in the number of MRIs. Estimates put the number of MRIs done in BC annually at 1 per 21 people, and 1 per 18.5 nationally.

Within the central NHA catchment area, we have piloted implementation of strict criteria for musculoskeletal MRIs with some early success in reducing their numbers. This hopefully will be expanded across the whole region.

I have found it frustrating and ironic that ideas and efforts to curb the wasteful spending of health care money are not met with more acceptance from health administration and policy personnel. It seems the mantra is "more is better," even when it is misguided and wasteful.

—Roger Purnell, MBChB, FRCSC
Prince George

Re: Opioid prescribing

Thanks to Drs Hawley and Gallagher for their helpful articles about opioid prescribing in the November 2021 issue of the *BCMJ*. They should be required study for primary care physicians, especially those reluctant to prescribe any form of opioid, including codeine compounds.

Their guest editorial acknowledges the reluctance, giving a background for such policy by the prescribing physician, including the concern of receiving a letter from the College. Despite their reassurance that this is a simple, necessary prescribing enquiry, the actuality may feel more like an inquisition. Thirty years ago, a College letter about my prescribing of liquid codeine as an antitussive resulted in a face-to-face interlocution, with the strong suggestion that such prescription was proscribed; use off-the-shelf preparations. The experience was very unpleasant; I became a nonprescriber. A different atmosphere is needed if primary care physicians are to continue to be opioid prescribers.

One of the articles also mentions that there have been calls to delist codeine, for a variety of reasons. However, for some migraine patients

Continued on page 58

Letters *Continued from page 56*

who do not respond to triptans and ergot, Tylenol #3 remains an effective rescue preparation when administered early in the attack. Even when migraine patients include classic aura in their range of symptoms, it is difficult enough to persuade a personal physician to prescribe a few Tylenol #3s in today's opioid climate, let alone have to escalate that request to a stronger alternative if codeine preparations were to be no longer available. Delisting will predictably result in migraine sufferers ending up under the aggravating bright lights of the ER department for hours, awaiting IV metoclopramide or ondansetron to abort their attacks (personal experience).

—Anthony Walter, MD
Coldstream

Doctors Helping Doctors 24 hrs/day, 7 days/week

The Physician Health Program of British Columbia offers help 24/7 to B.C. doctors and their families for a wide range of personal and professional problems: physical, psychological and social. If something is on your mind, give us a call at 1-800-663-6729. Or for more information about our services, visit www.physicianhealth.com.

News

We welcome news items of less than 300 words; we may edit them for clarity and length. News items should be emailed to journal@doctorsofbc.ca and must include your mailing address, telephone number, and email address. All writers should disclose any competing interests.

Prepare for the unexpected with the contingency planning toolkit

When it comes to treating patients, doctors are always prepared to deal with the unexpected. Since many doctors are business owners as well, it's important to prepare for unexpected situations that may disrupt delivery of essential services. Potential threats may include fire, flood, facility damage, medical emergencies, sudden death, or prolonged absences.

Doctors of BC's new initiative, Business Pathways (www.doctorsofbc.ca/managing-your-practice/business-pathways), has developed a contingency planning toolkit that provides clear information and outlines steps on how to:

- Confirm your insurance coverage.
- Assign key roles and responsibilities.
- Create and mobilize a communications plan.
- Complete a critical record inventory.
- Create a schedule for review.
- Solidify your personal contingency plans and estate.

Business Pathways will be developing more resources in the coming months to help doctors with the operational side of running their business.

If you have feedback and questions, please contact Julia Dreyer at jdreyer@doctorsofbc.ca.

Value of accidental death and dismemberment insurance

Unlike conventional underwritten life insurance that requires the applicant to provide proof of good health to determine eligibility for coverage, there are no health or lifestyle questions necessary to obtain accidental death and dismemberment (AD&D) coverage. AD&D provides coverage to the insured in case of dismemberment or accidental death due to an unexpected event. Coverage begins immediately upon the initial premium payment. It is designed to pay a lump sum tax-free benefit if you lose your life, limbs, use of limbs, eyes, speech, or hearing due to an accident.

We are fortunate to live in a beautiful province offering a wealth of outdoor activities close to our homes, and it's not uncommon to find underwritten life insurance issued with an exclusion for hazardous sports or activities. A few of the most common exclusions are backcountry skiing, heli-skiing, rock climbing, and mountaineering. However, a serious injury or death can also result from everyday activities such as an automobile accident, slip and fall, choking, or drowning.

Demand for AD&D coverage is increasing, especially among those who have financial dependants such as a spouse, children, or other family members who may not have any life or disability insurance. The AD&D plan is also ideal if the insured or family member would typically be uninsurable or receive a policy with exclusions. In a worst-case scenario, AD&D helps ensure you and your loved ones continue their standard of living should you suddenly become injured or pass away due to an accident.

The schedule of covered losses is comprehensive, and the benefit amount varies depending on the claim. Death benefits are paid at 100% of the benefit amount. In contrast, the loss of use of one hand would pay 67% of the benefit amount. The plan also includes 26 supplemental benefits such as repatriation, rehabilitation, and/or spousal retraining benefits, to name a few.

Doctors of BC offers members individual or family coverage, in $100 000 increments