Letters to the editor

We welcome original letters of less than 500 words; we may edit them for clarity and length. Letters may be emailed to journal@doctorsofbc.ca or submitted online at bcmj.org/submit-letter and must include your city or town of residence, telephone number, and email address. Please disclose any competing interests.

Planetary health versus travel

At the bottom of the first table of contents page of the November 2023 issue of the *BCMJ* is a list. The list documents six things the journal is doing to minimize its environmental impact.

On the back cover of that issue is an advertisement for a medical conference: Antarctica 2025: Unconventional Conventions. I see this as a climate misadventure. Organizers, speakers, and participants should consider how their participation contributes to the disruption of the climate.

With reports that the last 12 months have been the hottest ever recorded and October 2023 being 1.3 °C hotter than any October on record,[1] everyone should not just question the value of an Antarctic travel conference but also repudiate this activity.

It is time to stop this type of planet-killing tourism disguised as CME.

Primum non nocere.

I suggest BC physicians refuse this type of CME.

—Douglas J. Courtemanche, MD, MS, CRCSC
Vancouver

Reference

1. Hansen J, Sato M, Kharecha P. Groundhog Day. Another gobsmackingly bananas month. What's up? 4 January 2024. Accessed 24 January 2024. www.columbia.edu/~jeh1/mailings/2024/Groundhog.04January2024.pdf.

Reframing chronic pain conversations

High-impact chronic pain affects quality of life and causes anxiety.[1] Affected individuals are more frequently prescribed opioids than those suffering from mild to moderately bothersome pain.[2] Management of this complex condition adds to the burden experienced by burned-out family doctors.

Psychosocial factors influence pain and patients' ability to manage their symptoms. Patients overwhelmed with chronic pain may find supportive self-management programs difficult to follow. An effective patient–provider partnership can be compromised if the patient feels they are to blame for their lack of progress.

Chronic pain already comes with the burden of stigma.[3] The experience of chronic illness may change the way individuals view themselves and the world. They can experience the environment as dangerous and feel they cannot effect change.[4] This leads to a decreased sense of self-efficacy. Reframing the pain conversation can reduce the risk of provoking a shame-based response.

Introducing the limbic system as an umbrella term used to explain neuroplastic changes in the brain explains associated anxiety with pain.[1] Framing the conversation around chronic pain causing alert or alarm in the limbic system turns the focus to chronic pain as the culprit, not the patient. The stress of pain is then connected to emotions, actions, memory,[5] and the downstream consequences of high alarm: maladjusted survival responses, associated neurohormonal changes, increased inflammation, and central sensitization causing a cycle of pain and anxiety.

Multiple other pain influencers can then be addressed, including the stress of unemployment, financial hardship, health inequities, and compromised interpersonal relationships and social interactions, which negatively impact coping mechanisms.

A structured approach and Internet-based chronic pain tools make this approach possible in a busy medical practice.

Pain questionnaires can be used prior to an appointment to identify the presence of high-impact chronic pain. A 20-minute counseling appointment is essential for a narrative interview, with the opening question "Please tell me everything you feel I should know about your pain."

Subsequent follow-up counseling appointments are used to address biological causes for chronic pain. Endorse symptoms,

and acknowledge that exact causes for pain cannot always be identified. Repeatedly assure patients of negative findings. Reassure patients there is no imminent harm and that conditions requiring surgery have been eliminated. Explore other forms of medication that can impact central sensitization and chronic inflammation.

Ask patients what they feel is the cause of their pain. Using questionnaires, reassess the impact of pain on their quality of life and use these measures as a tool to address movement, sleep, diet, socialization, and mental health.

Multiple tools for patients are available to explain pain, neuroplasticity, central sensitization, and the inflammatory neurohormonal cascade of sympathetic arousal.

Education tools are available online (https://youtu.be/b5hTjigmXYUA).

Links to management tools for overwhelming pain, physical and emotional, can be emailed to patients (https://painimprovement.com/overwhelmed-pain).

Pain coaches and education can be accessed through https://painbc.ca/find-help/support-programs/coaching and www.selfmanagementbc.ca.

Regular office visits providing supported self-management can assist patients to change entrenched negative cognitions and behavior and help improve emotional and physiological regulation.

An understanding of the biological and psychological effects of chronic pain through a graduated education program will decrease a sense of shame and increase interpersonal effectiveness and interest in social connectedness. The goal is to empower patients and support them in discovering joy in their lives again.

—Judy Dercksen, MD
Quesnel

References

1. Chen T, Wang J, Wang YQ, Chu YX. Current understanding of the neural circuitry in the comorbidity of chronic pain and anxiety. Neural Plast 2022;2022:4217593.
2. Von Korff M, DeBar LL, Krebs EE, et al. Graded chronic pain scale revised: Mild, bothersome, and high-impact chronic pain. Pain 2020;161:651-661.
3. Perugino F, De Angelis V, Pompili M, Martelletti P. Stigma and chronic pain. Pain Ther 2022;11:1085-1094.
4. Gatchel RJ, Neblett R, Kishino N, Ray CT. Fear-avoidance beliefs and chronic pain. J Orthop Sports Phys Ther 2016;46:38-43.
5. Rolls ET. The cingulate cortex and limbic systems for emotion, action, and memory. Brain Struct Funct 2019;224:3001-3018.

Re: BC has the tools to address the drug poisoning emergency

The editorial by Dr Michael Schwandt in the December issue of the *BCMJ* [2023;65:365-366] proposes dealing with the drug poisoning emergency by decriminalizing drugs, reducing stigma, and increasing the safe drug supply. The problem with this approach is that it looks at only one outcome, and that is to prevent drug poisoning and drug poisoning deaths. Unfortunately, there are many more issues to this complex problem.

There are enormous social costs associated with normalizing drug use. We have witnessed the ghettoization of Hastings Street in downtown Vancouver, the near extinction of Chinatown, and the open use of drug injections across the entire downtown of Vancouver. It is ironic that it is illegal to drink alcohol or smoke cigarettes in many public places when injecting opioids is legal.

Our neighbors to the south have witnessed the destruction of the downtown cores of Portland, Seattle, and San Francisco due largely to permissive drug policies. These cities are rejecting this approach and are now recriminalizing and discouraging drug use. A similar story is unfolding in Portugal.

A safe drug supply, in my view, appears to be increasing accessibility to drug use, and in some cases safe drugs are being diverted so that addicted persons can purchase fentanyl-based products.

I am concerned that we are setting a very poor example for young people by normalizing drug use. Contrary to the editorial, I want to stigmatize drug use so that it does not become an attractive lifestyle for our children, teenagers, and young adults. There are some consumer groups who defend the rights of adults who use drugs and the subsequent lifestyle of crime that supports drug use. This, in my view, is a mistake.

The current policies are simply not working, as evidenced by the persistently high rates of overdoses and deaths. It is time, in my view, to try a different approach. Already, the provincial government has reversed policies on drug use that allowed drug injections in parks and near schools.

I do not pretend to provide a comprehensive solution to the current problems, but we need a broader approach than simply supplying safe drugs to persons addicted to drugs. We need to consider the extensive social problems that are created by normalizing drug use. We certainly need more housing and treatment services. There may be a role for more coercive treatment approaches. Lifesaving approaches such as certification under the Mental Health Act need to be reviewed.

It is time for citizens to seize the agenda and to not rely on advocacy groups and so-called experts to get us out of this crisis.

—Derryck H. Smith, MD, FRCPC
Vancouver

I urge Dr Schwandt, a member of the *BCMJ* Editorial Board, to resist the temptation to quote British Columbia's outgoing chief coroner, Lisa Lapointe, as though her statements are fact. Dr Schwandt quoted the following misrepresentation from the November 2023 BC Coroners Service Death Review Panel report[1] in his editorial [*BCMJ* 2023;65:365-366]: "as many as 225 000 [people] are at risk of poisoning from unregulated drugs, [but] only 4476 people were prescribed safe supply medications in July 2023."

The impression these numbers give is that fewer than 5000 people out of 225 000 are receiving treatment. In both Dr Schwandt's editorial and the coroner's report, the goal is to demonstrate an urgent need to expand safe supply.

However, the problems with these numbers are manifold. First, there is an

important number that is simply missing: 25 000. That is the approximate number of people in BC being prescribed opioid agonist therapy—primarily methadone and suboxone—which is an effective treatment for opioid use disorder. This number was buried in the coroner's report in an appendix on page 42—far enough from the prominent pull quotes as to be almost invisible.

The number 225 000 is also problematic. This number is derived from a 2019 national survey of illegal drug use, which was then retroactively applied to BC. The resulting statistic was of such uncertain accuracy that its 95% confidence interval was 92 000 to 221 000. This number was then arbitrarily inflated based on an assumption that drug use "has increased" since 2019. The final result—a range of 125 000–225 000[1]—is of clearly limited statistical value, and yet the upper figure has been quoted often enough in the press (and now the *BCMJ*) that it has begun to acquire an undeserved ring of truth.

What makes this data invention even more egregious is that the original 2019 statistic included *all* illicit drug use, including cocaine, methamphetamine, ecstasy, hallucinogens, heroin, and salvia. Could all these drug users benefit from increased access to safe supply opioids? Of course not. Many of them do not even use opioids. Their inclusion in the data serves only to exaggerate the need for expanded safe supply.

If we look at actual facts instead of carefully edited and invented statistics, we see that far more people are already on effective treatment than the chief coroner would have us believe: 30 000 instead of 5000. Furthermore, far fewer people would benefit from expanded safe supply: perhaps 100 000–125 000. Not 225 000.

—Mark Mallet, MD, CCFP
Victoria

Reference

1. BC Coroners Service. BC Coroners Service Death Review Panel: An urgent response to a continuing crisis. Report to the chief coroner of British Columbia. 2023. Accessed 10 January 2024. www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/an_urgent_response_to_a_continuing_crisis_report.pdf.

Author replies

I thank Drs Smith and Mallet for their correspondence.

The toxic drug poisoning crisis is a complex issue, requiring action across a continuum including mental health, trauma prevention, addiction treatment, and harm reduction. It cannot be concluded that harm reduction measures to provide a safer supply of drugs have failed, when at current scale these measures have reached only a small fraction of those potentially at risk. Further, while there is little to suggest that availability of a safer supply normalizes and increases drug use, there *is* evidence of positive impacts among those who might otherwise access the toxic illicit supply. In fact, in the weeks since publication of this editorial, a new BC-based study has been released showing decreased drug poisoning and all-cause mortality among people receiving safer supply.[1]

The number of people at risk of illicit drug poisoning in BC is large, and estimates of this heterogenous population are by their nature inexact. Expert researchers have applied peer-reviewed and published methodologies to examine the population at risk. For example, using linked health data sources, a team of BC researchers identified a provincial cohort of people with substance use disorder comprising 162 099 individuals.[2] Meanwhile, people who use drugs but do *not* meet criteria for a substance use disorder in administrative health data are also at risk: people fitting this description make up a substantial proportion of those dying of illicit drug poisoning in BC. Estimates and related ranges realistically reflect uncertainty regarding the number of people at risk from using illicit drugs, and an estimated at-risk population of up to 225 000 is quite coherent with the more restrictive population estimates of people with substance use disorder in BC.

The crucial fact is that many British Columbians are at ongoing risk of death due to the toxic illicit drug supply. The product of this population size and the unpredictability of the drug supply are such that an average of seven people in our province die of illicit drug poisoning every day. Long-standing and important programs of opioid agonist treatment and addiction treatment have not adequately addressed this issue, and safer supply approaches remain underutilized.

The evidence base for safer supplies of drugs continues to grow, and urgent action could help prevent further deaths in our communities.

—Michael Schwandt, MD, MPH

References

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2. Homayra F, Pearce LA, Wang L, et al. Cohort profile: The provincial substance use disorder cohort in British Columbia, Canada. Int J Epidemiol 2021;49:1776.