# Letters to the editor

**We welcome original letters of less than 500 words; we may edit them for clarity and length. Email letters to journal@doctorsofbc.ca and include your city or town of residence, telephone number, and email address. Please disclose any competing interests.**

## Re: The OurCare Standard

Kudos to Drs Mitra, Pham, and Lavergne for promoting long-overdue transformation in Canadian primary care so there can be equitable access for everyone [*BCMJ* 2025;67:109-112]. Their description of the changes in the provision of primary care over the last 50 years is insightful. In this time of scarcity, the solution cannot be more doctors, more nurse practitioners, more nurses, more money, alone. It requires a refinement, selecting appropriate work for the doctor or nurse practitioner, and expansion of the portion of primary care demands being cared for by other members of a robust primary health care team so that patient panels can grow.

**—Rick Potter-Cogan, CCFP**
**Comox**

## Name change suggested for the College of Physicians and Surgeons of BC

As we review proposed bylaw changes of the College of Physicians and Surgeons of BC (CPSBC) under the 2022 Health Professions and Occupations Act, we might want to reflect on and recommend a new name for the CPSBC that is more congruent with what it has become. Despite its recent rebranding, the word *college* no longer seems to fit.

The *Oxford English Dictionary* defines *college* as "an organized society of persons performing certain common functions and possessing special rights and privileges; a body of colleagues, a guild, fellowship, association."[1]

When I gratefully received my licence to practise in 1987, I was registered as a member of the CPSBC. We are no longer considered *members* but are now *registrants*. Under the new bylaws, we will be referred to as *licensees*.

Ten years ago, the CPSBC stopped supporting the Physician Health Program. In 2022, the CPSBC surveyed its registrants and found that only one in five thought it was trusted, fair, and accessible; only 14% considered it approachable; and only 12% said it was transparent.[2] None of this fits well with "a body of colleagues, a guild, fellowship" or even an "association" to which one would voluntarily belong.

Another definition of *college* is "a society of scholars . . . formed for purposes of study or instruction."[1] Last year, the CPSBC closed its medical library and ceased its services that supported the research and continuing education of its registrants.

Perhaps Doctors of BC can advocate for a name change for the CPSBC that more accurately reflects its evolving function. We have only to look to other jurisdictions, like the United Kingdom or Australia, for inspiration. For example, we could be proud licensees of the new General Medical Council of BC or the BC Medical Licensing Board.

**—Eugene R. Leduc, MD**
**Victoria**

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## Re: Prescription factors contributing to new long-term opioid use in BC

We appreciate the contribution of Dr Xu and colleagues in their article "Prescription factors contributing to new long-term opioid use in British Columbia between 2013 and 2017."[1] Their work highlights historical prescribing trends and invites dialogue about opioid prescribing and policy in our province.

We offer this letter in the spirit of collaboration, hoping to deepen the conversation around the role of prescribing in the context of BC's complex and evolving toxic drug crisis.

We would like to clarify a few points raised in the article. The introduction references a report that shows a 17.6% national prevalence of long-term opioid use; however, the source cited is referring to the proportion of individuals *already prescribed* opioids who go on to longer-term use.[2] In contrast, the 7.2% prevalence reported in this study refers specifically to opioid-naive patients—an important distinction that could easily be misinterpreted without additional context. In the discussion, these figures appear to be conflated, which may lead readers to overestimate the prevalence of long-term opioid therapy in the broader population.

We also note that the study may have included opioid formulations typically used for cough suppression (e.g., codeine syrups) or opioid agonist therapies (e.g., methadone, buprenorphine). Long-term adherence to medications used in managing opioid use disorder is clinically appropriate and often lifesaving. Clarifying whether these formulations were excluded would help readers better understand the findings, especially

in interpreting unexpected prescribing patterns (e.g., among pediatric patients).

We encourage attention to the role of opioids in evidence-based care. Opioids remain a cornerstone of cancer pain and palliative care. In 2022, more than 237 000 people in BC were living with cancer,[3] and many rely on opioids for effective symptom management.[4] Understanding the clinical indications behind prescribing—and how they relate to patient outcomes—is key to evaluating the appropriateness of current practices.

The article references US-based trends in opioid mortality to frame the significance of the findings.[5] We respectfully suggest caution here. While international comparisons can be informative, BC's public health landscape is notably different. Overdose deaths in BC are now overwhelmingly driven by the unregulated drug supply, particularly illicit fentanyl and its analogues. A BC-based study found that nearly 79% of drug toxicity deaths in BC involved nonprescribed fentanyl, while only 2% were linked solely to prescribed opioids without any illegal substances.[6] Contextualizing local prescribing data within this broader public health reality is essential to avoid misdirected policy responses.

Finally, recent BC-based research, including work by Dr Slaunwhite and colleagues,[7] shows that prescribed opioids can reduce mortality among people with opioid use disorder. Prescribing metrics that do not account for clinical context may unintentionally undermine care for patients who already face significant stigma and structural barriers.

We thank the authors for their work and hope these additions help support an even more nuanced and patient-centred conversation about opioid use and policy in British Columbia.

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## Authors reply

We thank Drs McCracken, Hawley, Panagiotoglou, Lavergne, and Gomes and Ms Peterson for their thoughtful letter about our article on new long-term opioid use in BC.[1] Our understanding is that they are concerned our study may result in a policy response that would negatively impact patient populations benefiting from prescribed opioids. This was not our intention. We hope our reply to each discussion point will provide clarification. In our article, we aimed primarily to describe the specific BC data we had access to, and we were cautious to provide recommendations given the limitations of our data set.

We presented the prevalence of national long-term opioid use from the Canadian Institute for Health Information in the introduction to provide readers with context about long-term opioid use in Canada.[2] We agree this is a different patient population from the 7.2% of opioid-naive users that became new long-term opioid users within our 4-year study period.[1] Our focus was to determine the BC-specific initial opioid prescription practices, as this has been shown to be a strong predictive factor in ongoing opioid use.[3,4] Initial prescribing practices across the world vary substantially.[5] Opioids, in excess of clinical need, increase the risk of opioid dependency, recreational opioid use, opioid sharing and diversion, accidental overdose, and death.[6]

Our 2025 article was the second of two on this subject, and our methodology section was therefore more succinct, as we referenced our previous, more detailed report from 2021.[7] We used the World Health Organization Collaborating Centre for Drug Statistics Methodology's Anatomical Therapeutic Chemical classification system to create a list of possible opioids.[8] For our study, only the classifications of "opioids" and "drugs used in opioid dependence" were used. "Cough and cold preparations" were excluded.

For our 2025 article, we felt our definition of new long-term users was clear: individuals who were opioid naive (no opioid prescriptions in the 180 days prior to the first opioid prescription) and not initially prescribed methadone or buprenorphine.[1]

In a previous study by Crabtree and colleagues, the authors found that for fatal drug overdoses in BC during the period of 2015–2017, only 2% were associated with a prescribed opioid (within 60 days of death), and another 6.7% were associated with a combination of prescribed and nonprescribed opioids.[9] While this is an important finding, the toxic drug crisis in BC has evolved, with more involvement

of other drugs.[10] Moreover, in Gomes and colleagues' analysis of opioid-related deaths between 2013 and 2016 in Ontario, 1 in 3 deaths were associated with an active opioid prescription, and 75% of deaths were associated with an opioid dispensed within the 3 years preceeding death.[11] Although the aforementioned studies differ in how they analyzed opioid prescriptions in association with fatal drug overdoses, it's important to recognize the possibility that opioid users often start their opioid journey with prescription opioids related to an acute injury or illness. Nonetheless, we agree that contextualizing our study data within a local context is key for any policy response.

Dr McCracken and coauthors emphasized the key role that opioids have in patient care, and we completely agree. We were careful not to comment on the appropriateness of long-term opioid therapy, given that we were not permitted access to prescription indication data.[1] Moreover, we did not specifically look at the patient population that would benefit from prescribed opioids for opioid use disorders, as described by Slaunwhite and colleagues.[12]

Despite not having data on indications and outcomes, we were still able to outline prescribing practices. We agree with Dr McCracken and coauthors that the article on its own should not lead to a specific policy response. Rather, we hope that future work will build on this study's findings by incorporating indications, outcomes, and more recent data to better understand opioid prescribing practices.

Thank you again to Dr McCracken and her team for their letter. We also thank the *BCMJ* Editorial Board for providing our team an opportunity to reply.

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