Letters | Correspondance

Correction

In the article "Patient poverty and workload in primary care. Study of prescription drug benefit recipients in community health centres,"[1] which appeared in the April issue of *Canadian Family Physician,* the acknowledgment was inadvertently omitted. It should have read as follows:

Acknowledgment

We acknowledge the contribution to this study of the foundational work done through a collaboration between the Institute for Clinical Evaluative Sciences (ICES) and the Association of Ontario Health Centres. We particularly wish to thank **Dr Rick Glazier** and **Mr Brandon Zagorski** for their assistance. This study was supported by ICES, which is funded by an annual grant from the Ontario Ministry of Health and Long-Term Care. The opinions, results, and conclusions reported in this paper are those of the authors and are independent from those of the funding sources. No endorsement by ICES or the Ontario Ministry of Health and Long-Term Care is intended or should be inferred.

The authors apologize for any confusion or inconvenience this omission might have caused.

Reference

1. Muldoon L, Rayner J, Dahrouge S. Patient poverty and workload in primary care. Study of prescription drug benefit recipients in community health centres. *Can Fam Physician* 2013;59:384-90.

Poverty and universal health care

In the April issue of *Canadian Family Physician*, Dr Hooker paints a very clear picture of several challenges that primary care providers face when caring for disadvantaged populations.[1] But in a universal health care system like Canada's, not every health care provider who cares for individuals living in poverty has specifically chosen to do so. In Ontario, every primary care model cares for poor patients,[2] but there are some practices that might attempt to "screen out" such clientele.[3] Dr Hooker is quite right that we need settings in which teams of professionals work with disadvantaged communities to deliver a spectrum of care, from addressing the social determinants of health to providing comprehensive primary care. In our universal health care system, all health care providers must have nonjudgmental attitudes toward poor patients, as well as knowledge about and access to the resources that address the special issues of people living in poverty.

—Laura Muldoon MD FCFP
Ottawa, Ont

Competing interests

Dr Muldoon practises in a community health centre.

References

1. Hooker RS. Working with the medically underserved. *Can Fam Physician* 2013;59:339-40 (Eng), 347-8 (Fr).
2. Glazier RH, Zagorski BM, Rayner J. *Comparison of primary care models in Ontario by demographics, case mix and emergency department use, 2008/09 to 2009/10. ICES Investigative Report.* Toronto, ON: Institute for Clinical Evaluative Sciences; 2012.
3. Olah ME, Gaisano G, Hwang SW. The effect of socioeconomic status on access to primary care: an audit study. *CMAJ* 2013;185(6):E263-9. Epub 2013 Feb 25.

Complexities of prescribing

I read with interest Dr Ladouceur's editorial, "Opioid dependence," in the April issue of *Canadian Family Physician*.[1] Being on the "front line" of medicine with my "attached patients" and in complementary walk-in care, I am very much aware of the difficulties in providing balanced care to those with chronic nonmalignant pain. The most onerous aspect is the solitude one experiences, with the regulatory college on one side looking over your shoulder, the rare community physician willing to care for such patients on another side, and then the patient in front of you needing the assistance with pain. When you seek to access support or wisdom in what you are trying to achieve in your management plan, there is such an incredible paucity of resources. Expert colleagues in this area have such extensive waiting lists (anywhere between 1 and 2 years, if lucky) as they rightfully struggle with their heroic workloads (which speaks volumes about how few are willing to pick up the challenges), such that they are forced to simply advise in a brief format on what direction to take. The workload quickly returns to the primary care physician to "test" whether the suggestions work or determine if the replies are helpful. The longer-term care remains to be the single dilemma of that primary care physician. Other "multidisciplinary team members" whose presence and input are so often advised to be part of the standard approach for the management of such complex patients are in reality rare as hen's teeth. I would be very interested in the views of others on this point.

—John L. de Couto MD
New Westminster, BC

Competing interests

None declared

Reference

1. Ladouceur R. Opioid dependence. *Can Fam Physician* 2013;59:333 (Eng), 334 (Fr).

Timed-release oxycodone

In the April issue of *Canadian Family Physician*, Dr Uddin[1] stated that Purdue Pharma had described OxyNEO (a timed-release oral oxycodone) as "tamper proof"; however, at no time did Purdue Pharma make

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the claim that OxyNEO was tamper proof. Describing the product as tamper resistant is not within Health Canada–approved labeling rules. What we at Purdue Pharma have said about OxyNEO is that the tablets have been hardened to reduce the risk of their being easily broken, crushed, or chewed in order to release the medication more quickly. When the tablet is dissolved it forms a gel, making it more difficult to inject. Purdue Pharma is well aware of the Internet recipes for defeating the controlled-release properties of OxyNEO. Most of these methods, if reliable, involve a lot of time and effort. There are epidemiological studies under way to determine whether OxyNEO is resulting in a decrease of misuse and abuse. Results from these studies are being reported to Health Canada.

—Randy R. Steffan
Pickering, Ont

Competing interests
Mr Steffan is Vice President of Corporate Affairs at Purdue Pharma, the manufacturer of OxyNEO.

Reference
1. Uddin F. Hope in Fort Hope. First Nations community is winning the battle against prescription drug abuse. *Can Fam Physician* 2013;59:391-3.