More tools against misinformation

The excellent article on preventive health care and the media in the November issue of *Canadian Family Physician*[1] reminded me of the degree to which many medical practitioners (me included) might be conned into swimming with the tide of misinformation, especially with regard to some screening tests. This often surreptitious acquiescence to media hype and sales talk comes with a huge price tag to health care, apart from patient implications. Besides the book *Conspiracy of Hope* by Renée Pellerin[2] (relating to breast cancer) recommended in the article, I also recommend *Overdiagnosed* by Dr H. Gilbert Welch and colleagues,[3] which covers a wide spectrum of diseases. The Canadian Task Force on Preventive Health Care (**https://canadiantaskforce.ca**), as mentioned in the article, is a worthy go-to resource for user-friendly advice, and their various 1000-patient tools should be near at hand in the clinic room. I highly recommend this article as a breath of fresh air for an often confusing medical milieu.

—Graham de L. White MD CCFP(LM)
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Competing interests
None declared

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Power of words and expectation

I thank Dr Kalpit Agnihotri[1] for his commendable article on the immense power we as care providers and prescribers can wield when it comes to how our patients respond to medication. The placebo and nocebo effects are inextricably linked to how we frame our discussions about therapeutic options, and the conscious or unconscious expectations that are thereby created. One particular approach that I have found tremendously helpful to navigate these tricky waters in my own practice is the medication interest model, described in detail in Dr Shawn Christopher Shea's book of the same name.[2] Dr Shea, a psychiatrist with decades of expertise in the careful art of interviewing, illuminates with many practical examples how we can tailor our discussions to respond to patients' concerns and overcome the barrier of medication indifference that often seems endemic. I suspect that such an approach might yield promising results with respect to decreasing the nocebo effect as well, and I would recommend this publication to all my colleagues who have an interest in more effective therapeutic counseling.

—Edward S. Weiss MD CCFP
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Competing interests
None declared

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Disappointed in platform

I read Dr Dale Dewar's letter in the December issue[1] and am disappointed to see that she was given a platform to express her views, as she has publicly expressed discriminatory remarks against Jewish people and Israelis.[2] She diminishes the importance of the Holocaust and belittles its effect on the Jewish people. Her lack of remorse for her comments and lack of understanding of Jewish history and cultural sensitivity make her a terrible choice for presenting any viewpoint concerning injustice.

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Competing interests
None declared

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2. Brunskill J. Strongly worded posts by Regina Green candidate decried by Holocaust studies group. *CBC News* 2019 Sep 13. Available from: **https://www.cbc.ca/news/canada/saskatchewan/dale-dewar-green-party-1.5282368**. Accessed 2021 Jan 22.

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Methadone is methadone

As a pharmacist who has been dispensing methadone for more than 20 years to patients in and out of Ontario provincial jails, I read the article by Raski et al in the November issue[1] with interest (and gratitude to one

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3. **Tools for Practice:** Virtual versus in-person primary care visits (December 2020)
4. **Clinical Review:** Approach to hearing loss (November 2020)
5. **FPIN's Clinical Inquiries:** Association of first-line antidepressants and incident adverse metabolic effects (December 2020)

of the doctors on our team, who thoughtfully clipped this article out of his paper copy of *Canadian Family Physician* and provided it to me). When we transitioned from methadone to Methadose in Ontario, I braced myself for patients' reactions and prepared for some sort of backlash. What I found after the transition was that many of our patients started hearing about the complaints from people receiving methadone in British Columbia. But here in Ontario, my patients did not have this same experience.

The article does not really address in detail the main change that occurred with this transition, and issues that might arise from it: that all pharmacists in the country were compelled to stop making stock solutions from methadone powder and use the commercial product instead. I suggest the possibility that the issue with the transition to Methadose arises from the precision with which doses of methadone were formerly being prepared. The reason that provincial regulators decided to enforce Health Canada's Policy on Manufacturing and Compounding Drug Products in Canada (2009),[2] and compel pharmacists to stop preparing methadone solution in the back of our pharmacies was that, regardless of our level of skill, precision, and professionalism, we do not have the same degree of quality control in our pharmacies as does Big Pharma, and mishaps, although rare, did happen. Much as it behooves me to say so, the possibility exists that the extemporaneously prepared doses of methadone did not contain the same amount of methadone as when we started using the more precisely prepared commercial product. And this dose discrepancy perhaps was for some reason most extreme in British Columbia. Otherwise, why did we barely experience this problem in Ontario?

However, there might be another explanation that arises from an examination of the entire context of illicit drug use and what drugs are available on the illicit market, and how those might affect patients. Specifically, the rollout of Methadose in 2014 happened to coincide with the increasing presence of fentanyl in the heroin supply. Most people in opioid agonist treatment programs continue to use illicitly acquired drugs. If people who use opioids start unknowingly receiving fentanyl, and they persist with this use and do not overdose from fentanyl's 50-fold potency compared with heroin, their physical tolerance to opioids will increase; ergo, their usual dose of methadone will not be sufficient to suppress their opioid cravings. And as Vancouver, BC, is a port city, people who used opioids were likely to encounter fentanyl before most of the rest of the country. And yes, fentanyl has now unfortunately spread throughout Canada, but as it arrived in more inland cities, perhaps it more gradually supplanted other illicit drug sources than happened in Vancouver, so the tolerance of patients was more gradually affected. After all, back in the Oxycontin days, Oxycontin was the most trafficked opioid in Canada with the exception of 2 port cities: Montreal, Que, and yes,

Vancouver, where heroin remained the most prevalent opioid of illicit use until fentanyl came along.

I agree with your points regarding more community consultation. People with substance use disorder are among the most vulnerable of our citizens, and they especially do not like changes being imposed upon them without negotiation or discussion. But methadone is methadone, and it does not make any sense that there would be any difference. I appreciate your thoroughness in examining whether there was any pharmaceutical difference between formulations. I suggest that this problem encountered by some patients might have a more substantiative explanation, but given the impossibility of comparing the extemporaneously prepared doses made before 2014 with the current doses, and the complexity of determining the effects of the illicit drug supply on our patients, I do not know if this is a mystery we will ever solve.

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Competing interests
None declared

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Correction

Une erreur s'est glissée dans la traduction de l'article de Dossiers en soins palliatifs intitulé « Prise en charge du hoquet »[1] par Dr Cornelius J. Woelk, publié dans le numéro de juin 2011 du *Médecin de famille canadien*. Le mot « agoniste » doit être remplacé par « antagoniste », et le texte corrigé se lit comme suit :

> La chlorpromazine est un dérivé diméthylamine de la phénothiazine. Elle agit centralement comme antagoniste de la dopamine dans l'hypothalamus. Elle peut avoir des effets secondaires graves, comme l'hypotension, la rétention urinaire, le glaucome et le délirium. C'est pourquoi elle n'est généralement plus recommandée comme prise en charge de première intention. La dose habituelle serait de 25 mg 4 fois par jour en augmentant au besoin jusqu'à 50 mg 4 fois par jour.
>
> *Halopéridol.* Il a été démontré que l'halopéridol était efficace, probablement aussi par l'entremise d'une action antagoniste de la dopamine. Il pourrait être mieux toléré que la chlorpromazine.

La version en ligne a été corrigée, et *Le Médecin de famille canadien* s'excuse de l'erreur et de toute confusion qu'elle aurait pu causer.

Référence

1. Woelk CJ. Prise en charge du hoquet. *Can Fam Physician* 2011;57:672-5 (ang), e198-201 (fr).

Can Fam Physician 2021;67:84. DOI: 10.46747/cfp.670284