tional. In the decade before the incentive fees, our communities had no trouble finding physicians to staff walk-in shifts, and many new graduates were deciding to do hospitalist work because they viewed financial disincentives to entering full-service family practice. Family physicians who loved their practice were choosing to take half days off to work in a walk-in clinic just to be financially competitive with their colleagues.

I have watched a gradual shift this decade whereby physicians are back in their offices, and new grads are coming to communities to set up a full practice. I believe this is a direct result of BC incentive payments allowing doctors to choose to practise long-term comprehensive medicine on a financially equitable playing field.

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National opioid crisis

Friesen and colleagues[1] have provided invaluable insight into unsafe opioid prescribing in Canada over a time when we have seen unprecedented increases in prescriptions for opioids[2] and consequently the number of associated harms, including death.[3]

As an opioid prescribing educator, I agree with Lucyk and Nelson's contention in their linked commentary[4] that we require improved prescriber education. However, given the breadth of the crisis, our approach to unsafe prescribing needs to be far more comprehensive, rational and coordinated.

An excellent example of the disconnectedness of our current efforts comes from British Columbia and the decision of its regulatory college to set new standards for opioid prescribing for chronic noncancer pain based on the recently released guidelines from the Centers for Disease Control and Prevention.[5] These new standards include what essentially amounts to a maximum dose of 90 MEQ (milligrams of morphine equivalent). Yet, as just one example, that province's formulary still carries transdermal fentanyl in doses more than four times this maximum in the form of 100 μg fentanyl patches (400 MEQ).

We know that decisions about what is available on formulary influences prescribing practices.[2,6] With multiple inconsistent factors influencing prescriber behaviour, how can we expect a consistent response from physicians? In no other area of medicine do we see, or would we tolerate, such divergence and inconsistency of prescribing practices.[7]

As we continue to recognize the lack of good evidence for the use of strong opioids in chronic noncancer pain (despite what Lucyk and Nelson claim about the effectiveness of fentanyl[4]) and the substantial harms associated with their use, it is time that policy-makers, regulators, educators, prescribers and the public come together to form a consistent, rational and safe approach to the use of these potent medications.

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Nasal irrigation

Little and colleagues show a modest effect of nasal irrigation in people with recurrent or chronic sinusitis.[1] Participants used a neti pot, which delivers the irrigation fluid to the lower part of the nasal cavity.

However, the openings of the sphenoid, ethmoid and frontal sinuses are located at the top of the nasal cavity. Irrigation can only reach these openings when the head is positioned upside down. This can be achieved by instilling the irrigation solution from a syringe, with the head in supine position and then tilted backward into nearly an upside down position, over the edge of a bed or over an exercise ball. When the person sits up, the liquid is drained into a bowl, aided by a vigorous outbreath through the nose. A 60-mL syringe allows for five instillations of c. 12 mL each in a few minutes.

This procedure can be repeated daily when sinus symptoms are present. Liquid spilled over the face needs to be wiped quickly, before it reaches the eyes, lest purulent nasal material cause conjunctivitis. Water should be chlorinated or boiled and cooled to prevent infection, including amoebic meningoencephalitis.[2]

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