Letters of fewer than 300 words are welcomed; they may be edited for clarity and length. Letters may be e-mailed (journal@doctorsofbc.ca), faxed (604 638-2917), or sent through the post.

Assisted suicide vs. end-of-life care

Since the media has been lending some attention to the topic of assisted suicide recently, I have a few thoughts that are probably less commonly heard and would not easily be portrayed in the media, which tends to be one-sided.

Our current Western worldview elevates the ethical principle of autonomy above all others. This has not always been the case and will not always be the case going forward, as the ethical principles favored by society tend to evolve through the ages.

When it is taken to the extreme, autonomy ends up with some humans harming others in order to preserve their own autonomy. I see assisted suicide as one of the results of an autonomy-first worldview that is out of balance.

What concerns me is the type of society that assisted suicide will lead to. When I say that, I do not mean that I am concerned about the slippery slope we might slide down over time. Though the slippery slope has been a grave concern for many when observing the developments in Europe (as one example),[1] that is not what I am referring to. I am referring rather to the direct, dramatic, and immediate change in society that will occur the very second an assisted suicide law is signed into existence.

The immediate change is this: that as soon as assisted suicide is allowed, it becomes a choice that everyone in the entire community has to make—not just a choice that some people can make but an option that everyone else has to choose not to take.

People can no longer rest in the knowledge that their disabilities, dependency, and suffering are not their fault: that they can guiltlessly depend on the kindness and compassion of the community around them to care for them faithfully and without resentment until the very end. Instead they will be left with the knowledge that every day that they continue to depend on the care of others it is by their own choice.

If a change like this is accepted by the government and the medical profession it would be given a high level of credibility and acceptability, putting people under pressure to choose suicide.

I do not think that people will frequently be bullied into making a decision to ask for assisted suicide, but it will rather be a more subtle societal expectation that will undermine people's true freedom of choice by making them feel that they are a burden to their loved ones and society. This effect is inescapable, and will hit hardest at the most vulnerable in society.

I would rather advocate for a society where caring is held in high regard, with no option of a person being considered a burden, or blame being placed on the sufferer. This requires a community-first worldview approach rather than an autonomy-first approach, wherein the consequences to the vulnerable are considered before the autonomy of the individual.

The right solution would involve harder work—getting involved in the lives of lonely and dying people to an extent that they feel welcome and know that their presence is valued, rather than leaving an offer of suicide continuously dangling in front of them.

—Allan Donkin, MD
Fort St. John

Reference

1. Pereira J. Legalizing euthanasia or assisted suicide: The illusion of safeguards and controls. Curr Oncol 2011;18:e38-45.

Re: Dr Haigh's editorial

I am writing to thank Dr Haigh for her recent editorial [Some stories are heartbreaking, some are heartwarming; this one is both, *BCMJ* 2013;55:409]. I also know Margaret Benson through the work I used to do at the Adult Cystic Fibrosis Clinic at St. Paul's Hospital. She is indeed an inspiration to those who meet her or hear her speak in advocacy for CF patients or transplantation. I recently saw her on TV and was reminded of those dark, perilous days before she received her new lungs—what a difference a successful transplant can make in the lives of the recipients, their families, and, in Margaret's case, society. It sent me to the computer to check that, indeed, I was registered as a donor. I hope everyone

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who reads this will do the same so others can fulfill their dreams of seeing the elephants.

—Lindsay Lawson, MD
Victoria

Re: Spinal manipulation in low back pain

In his brief summary for WorkSafeBC (Chiropractic treatment for injured workers, *BCMJ* 2013;55:432-433) Dr Jeffrey Quon provides two (and curiously only two) references to support the benefits of spinal manipulation in low back pain.

The first is a summary of worldwide practice guidelines, including guidelines from chiropractic groups, for therapy of low back pain, assembled by authors from a private, for-profit, chiropractic clinic in Buffalo, New York.[1] It is not difficult to suppose this review may have some minor bias.

The other reference is to a recent Cochrane review[2] on spinal manipulation in chronic low back pain (not acute pain after injury, as Dr Quon's title would suggest). The key sentence in the summary of this review is "… SMT (spinal manipulation therapy) has a small, statistically significant but not clinically relevant, short-term effect on pain relief . . . and functional status… compared to other interventions."

Hardly enthusiastic support for spinal manipulation covered by WorkSafeBC.

—Roy Preshaw, MD
Telegraph Cove

References

1. Dagenais S, Tricco AC, Haldeman S. Synthesis of recommendations for the assessment and management of low back pain from recent clinical practice guidelines. Spine J 2010:10:514-529.
2. Rubinstein SM, van Middelkoop M, Assendelft WJJ, et al. Spinal manipulative therapy for chronic low-back pain. Cochrane Database Syst Rev 2011;16: CD008112.

Dr Quon responds

I would like to thank Dr Preshaw for his response to my brief article on chiropractic treatment for injured workers on behalf of WorkSafeBC.

Owing to restrictions on the size and scope of the original article, it wasn't possible to include a lengthy reference list and detailed summary of the evidence on spinal manipulation. Nonetheless, no fewer than 10 international, independently developed, evidence-based clinical practice guidelines recommend spinal manipulative therapy (SMT) either more often, or at least as often, as other widely accepted interventions for low back pain. These include treatments such as reassurance, advice to remain active, nonsteroidal anti-inflammatories, and muscle relaxants.[1-10]

The article specifically references Dagenais and colleagues because

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this research summarizes the quality and recommendations both for multiple guidelines and for modalities other than SMT.[11] More importantly, it summarizes this information in a transparent and scientifically rigorous manner.

When they published their synthesis, Dagenais and colleagues were indeed employed by a for-profit organization (Palladin Health). However, this was neither as fee-for-service clinicians nor as advocates for any single profession. On the contrary, they were retained as scientific consultants (epidemiologists and spine specialists), charged with developing cost-effective treatment pathways for a large, managed care network. Their bias, if any, was toward reducing costs, rather than promoting costly and ineffective interventions.

The terms "acute" and "chronic" were intentionally omitted from the title of the article. This reflects existing service utilization patterns—many claimants initially see other care providers and are just as often as not beyond the acute phase of their injury before finding their way to a chiropractor.

My reference to a systematic review on the effectiveness of SMT for chronic, rather than acute, low back pain was also intentional,[12] because systematic reviews are generally more cautious in endorsing spinal manipulation for chronic low back pain, as compared with chiropractic care for acute low back pain.[4]

Finally, regarding the reference to a quote from Rubinstein and colleagues that "… SMT (spinal manipulation therapy) has a small, statistically significant but not clinically relevant, short-term effect on pain relief… and functional status… compared to other interventions,"[12] the often-overlooked corollary to this statement is that other widely accepted treatments for low back pain have a small, statistically significant, but not clinically relevant, worse short-term effect (on pain relief and functional status) when compared to SMT.

Admittedly, the so-called "effect sizes" for all commonly administered stand-alone modalities for low back pain (acute or chronic) are only small to moderate.[13] Hence, it's important that research continues into the development of more effective and efficient interventions for low back pain. In the meantime, the current focus in evidence-based chiropractic is to promote multimodal, patient-centred therapy. This involves a combination of patient activation, SMT, and other modalities that demonstrate an equally moderate (as opposed to only small) treatment effect within randomized controlled trials.

Thank you for the opportunity to address these important issues.

—Jeffrey Quon, DC, MHSc, PhD (Epi), FCCS(C)
WorkSafeBC chiropractic consultant

References

1. Chou R, Qaseem A, Snow V, et al. Diagnosis and treatment of low back pain: A joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med 2007;147:478-491.
2. The Norwegian Back Pain Network. Acute low back pain: Interdisciplinary clinical guidelines. Oslo, UK: The Norwegian Back Pain Network, 2002.
3. Negrini S, Giovannoni S, Minozzi S, et al. Diagnostic therapeutic flow-charts for low back pain patients: The Italian clinical guidelines.EuraMedicophys2006;42:151-170.
4. van Tulder MW, Becker A, Bekkering T, et al. European guidelines for the management of acute nonspecific low back pain in primary care. Eur Spine J 2006;15(Suppl 2):S169-91.
5. Airaksinen O, Brox JL, Cedraschi C, et al. European guidelines for the management of chronic nonspecific low back pain in primary care. COST B13 Working Group on Guidelines for Chronic Low Back Pain, European Commission, 2005.
6. Australian Acute Musculoskeletal Pain Guidelines Group. Evidence-based management of acute musculoskeletal pain. Brisbane, Australia: Australian Academic Press Pty. Ltd., 2003.
7. Nielens H, Van Zundert J, Mairiaux P, et al. Chronic low back pain. Good Clinical practice (GCP). Brussels, Belgium: Belgian Health Care Knowledge Centre (KCE), 2006. Report No.: 48 C (D/2006/10.273/71).
8. Accident Compensation Corporation, New Zealand Guidelines Group. New Zealand acute low back pain guide. Wellington, New Zealand: Accident Compensation Corporation (ACC), 2004.
9. National Institute for Health and Clinical Excellence (NICE). Low back pain: Early management of persistent non-specific low back pain. London, UK: National Institute of Health and Clinical Excellence, 2009. Report No.: NICE clinical guideline 88.
10. Chou R, Loeser JD, Owens DK, et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: An evidence-based clinical practice guideline from the American Pain Society. Spine 2009;34:1066-1077.
11. Dagenais S, Tricco AC, Haldeman S. Synthesis of recommendations for the assessment and management of low back pain from recent clinical practice guidelines. Spine J 2010;10:514-529.
12. Rubinstein SM, van Middelkoop M, Assendelft WJJ, et al. Spinal manipulative therapy for chronic low-back pain. Cochrane Database System Rev 2011;16:CD008112.
13. Keller A, Hayden J, Bombardier C, et al. Effect sizes of non-surgical treatments of non-specific low-back pain. Eur Spine J 2007;16:1776-1788.

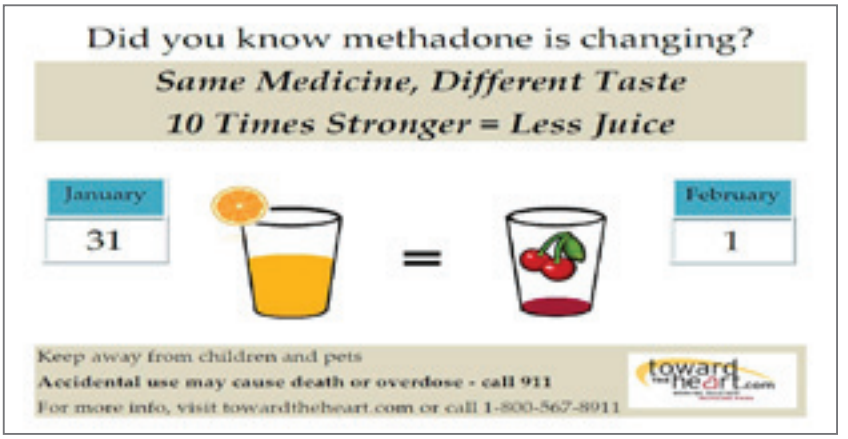
New methadone dosing: Overdose dangers

New methadone is 10 times more concentrated than the currently compounded anhydrous methadone solution. Are we ready to prevent potential overdoses?

Between 1 February and 1 March

2014 Pharmacare will transition patients on methadone for opiate substitution therapy and analgesia from the currently compounded anhydrous methadone solution (1 mg/mL) to Methadose, a 10 mg/mL solution.[1,2] Methadose has been available for purchase by pharmacies in Canada since 2012 and since 1973 in the US. Although the benefits of Methadose are understood—consistent dosing, longer shelf life, painful if injected, ability to be stored unrefrigerated (if not diluted)—the transition to this stronger medication presents a potential public safety risk.

In BC there are 14 572 patients registered[3] on methadone maintenance therapy (MMT) and some patients, under physician discretion, are permitted to take home daily doses (carries) up to a maximum of 35 days. Currently, methadone 1 mg/mL is dispensed diluted in an orange-flavored drink up to about 100 mL. Methadose is a red, cherry-flavored solution and, when undiluted, resembles many other commonly used over-the-counter medications. In BC new prescriptions are required starting 1 February 2014.



Methadose will be dispensed undiluted in small, individually dosed, child-resistant containers, which, if not locked up, could lead to increases in unintentional pediatric overdoses because 1 mL Methadose is a lethal dose in children.[4] The risk of unintentional adult overdoses during the transition is also of concern. There is a known risk of overdose from methadone during initiation, titration, and tapering of doses,[5] and now titration will be more difficult with the concentrated formulation. Patients on MMT should be adequately informed to prepare for the change, as the transition may increase psychosocial stress.

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Furthermore, in the event that doses are diverted, public awareness is important. By being aware of the upcoming changes and educating patients about the potential hazards, it is our goal to prevent methadone overdoses—especially through this transition period. For more information visit http://towardtheheart.com, or contact the BC Drug and Poison Information Centre at 1 800 567-8911.

—Olivia Sampson, MD, MPH
Vancouver
—Jane Buxton, MBBS, MRCGP, MHSc, FRCPC
Vancouver
—Ashraf Amlani, MPH
Vancouver

References

1. College of Physicians and Surgeons of British Columbia. BC methadone program. Accessed 7 January 2014. www.cpsbc.ca/programs/bc-methadone-program/methadose.
2. College of Pharmacists of British Columbia. Key initiatives. Accessed 30 December 2013. www.bcpharmacists.org/about_us/key_initiatives/index/articles144.php.
3. College of Physicians and Surgeons of British Columbia. Annual Report 2012/2013. Accessed 19 December 2013. https://www.cpsbc.ca/about-us/board-committees/annual-report.
4. Shadnia S, Rahimi M, Hassanian-Moghaddam H, et al. Methadone toxicity: Comparing tablet and syrup formulations during a decade in an academic poison center of Iran. Clin Toxicol (Phila) 2013; 51:777-782.
5. Latowsky, M. Methadone death, dosage and torsade de pointes: Risk-benefit policy implications. J Psychoactive Drugs 2006;38:513-519.

Re: How our leaders want to die—A call to action

As a long-time and avid reader of the *BCMJ* I look forward to reading the Proust questionnaire. These probing questions give us insight into the minds of some of our most prominent medical leaders.

I have recently joined the board of Dying with Dignity and head the Medical Advisory Council. I have also been involved in a number of legal cases in BC that have to do with the right-to-die issue.

I have been very impressed with a book I read recently, titled *Ending Life: Ethics and the Way We Die,* and in particular with a quotation that is attributed to Seneca: "Living is not the good, but living well. The wise man therefore lives as long as he should, not as long as he can… Just as I choose a ship to sail or a house to live in, so I choose a death for my passage from life. Moreover, whereas a prolonged life is not necessarily better, a prolonged death is necessarily worse."

A number of famous Canadians have recently addressed this issue as well. David Suzuki was recently quoted in the *Globe and Mail* as saying, "If I get Alzheimer's, frankly, I would just as soon be put down, because when my mind is gone, I'm gone. I'm just a body—a physical thing."

Dr Donald Low, a prominent Ontario physician who led the campaign against SARS, released a nationally distributed video a few days before his death, seeking help with an assisted death.

Even more recently, respected BC physician Dr Marco Terwiel wrote an editorial in the *Medical Post* outlining his medical conditions and stating, "I do not fear death, but I have witnessed too many times where I and my colleagues felt helpless to relieve the suffering of patients as they begged to be allowed to die." *[Dr Terwiel died 4 January 2014; see the article on page 36. —Ed]*

It is in this context that I reviewed the Proust questionnaires that address the question, "How would you like to die?"

The following is a brief summary

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of the responses:

- Reminiscing with my wife and family.
- Having a glass of beer.
- Not knowing how and when it happens.
- No nasty symptoms.
- In my sleep (three responses).
- Shot by a jealous husband.
- In my bed at home.
- Quickly.
- Instantly, no pain or suffering.
- Quickly and with dignity.
- In any fashion that would not inconvenience my family.
- Quietly with all my marbles.
- Skiing at Whistler.
- Reading Cicero.
- After a cigar, a glass of Bordeaux, and in my sleep.
- Suddenly.

There is a theme to these comments. Prominent doctors who have answered the Proust questionnaire all want to die quickly and painlessly after having enjoyed a full and complete life and perhaps while enjoying their favorite pastimes. What I find fascinating is that doctors frequently see exactly the opposite types of death, marked by lingering symptoms, dementia, ongoing pain, and misery. My sense is that there is more of the latter than the former available to us as we approach our end.

I was most dismayed when the CMA at the General Council 2013 voted not to even debate the end-of-life issues when it came to physician-assisted death. I find this appalling, given what we know and knowing how we would like to have our own lives end.

I would like the BCMA to take a leadership role on this issue and deliver on some of the wishes of the prominent physicians who answered the Proust questionnaire.

—Derryck H. Smith, MD
Vancouver

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Health Promotion released a paper entitled "Building Bridges: A call for a coordinated dementia strategy in BC."[5] The paper called for BC to develop a multifocal, coordinated dementia strategy, not just support research into prevention and treatment.

The province of BC released its Dementia Action Plan[6] in 2012, developed with the help of clinical, research, and policy experts with the goal of improving the care of patients with dementia during all stages of illness, through health care and service redesign. Components would include preventive and health promotion strategies, augmented primary care, high-quality hospital care when needed, and improved delivery of health services. It was recognized that improving dementia care at all stages of illness could decrease the need for hospitalization and institutional care.

An engaged, able, and active caregiver was recognized as a vital component in improving the life of a patient with dementia. Those without one are more likely to be placed at an earlier stage of their illness.[7] Services such as First Link, provided through the Alzheimer Society, offer support and education for patients and their caregivers at the earliest stages of the disease, when the patient has just been diagnosed. It is currently not available in all areas of BC.

It may be tempting to yield to financial pressures and cut back on funding for services directed toward care of the elderly in BC. However, this action will not only severely impact the elderly and their caregivers, but in the long run it will be detrimental to the health care system as well. Education for caregivers, including assistance with advanced care planning, support, accessible primary care, and respite care, could help them succeed in their goal of supporting their loved ones at home, reducing the need for placement or prolonged hospitalization. In acute care, up-front provision of appropriate, evidence-based management of elderly patients who have been hospitalized can also succeed in both increasing patient quality of life and decreasing overall care costs.

—Maria Chung, MD
Geriatrics and Palliative Care Committee

References

1. Fox MT, Persaud M, Maimets I, et al. Effectiveness of acute geriatric unit care using acute care for elderly components: A systemic review and meta-analysis. J Am Geriatr Soc 2012 60:2237-2243.
2. Wong RY. Discharge outcomes of older medical in-patients in a specialized acute care for the elders unit compared to non-specialized units. Can J Geriatr 2006;9:96-101.
3. Rockwood K. Commentary: What does the ACE unit trump? Can J Geriatr 2006; 9:102-103.
4. Lovell B, Wetherell MA. The cost of caregiving: Endocrine and immune implications in elderly and non-elderly caregivers. Neurosci Biobehav Rev 2011;35:1342-1352.
5. BC Medical Association. Council on Health Promotion. Building Bridges: A call for a coordinated dementia strategy in British Columbia. Accessed 6 January 2014. www.bcma.org/files/Dementia_Building_Bridges.pdf.
6. Government of British Columbia. Ministry of Health. The Provincial Dementia Action Plan for British Columbia. Accessed 6 January 2014. www.health.gov.bc.ca/library/publications/year/2012/dementia-action-plan.pdf
7. Mittleman MS, Ferris SH, Shulman E, et al. A family intervention to delay nursing home placement of patients with Alzheimer disease. A randomized controlled trial. JAMA 1996;276:1725-1731.