BCMJ BC Medical Journal

Letters of less 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.

Re: Assisted suicide vs end-of-life care

The average citizen, and perhaps even the average physician, may view death with dignity, a good death, aid in dying, compassionate care of the dying, and physician-assisted suicide as of the same species (*BCMJ* 2014;56:6). But criminal law draws sharp distinctions between suicide, mercy killing, assisted suicide, and death resulting from the nonprovision or withdrawal of treatment. Detractors of physician-assisted suicide appeal to various state interests, moral imperatives, and practical considerations. What if the patient does not die immediately? Do we proceed to euthanasia-assisted suicide? In countries where physician-assisted suicide has been available for years, it is known that 18% can initially fail or linger for hours or days. How many months will be assessed as final months—an arbitrary choice to begin with—and who gets to decide?

The fact that a slippery slope exists is undeniable. It is the steepness of the slope that we are debating and trying to control. The Netherlands started in the late 1970s with physician-assisted suicide and belatedly progressed to statutory recognition of the process and euthanasia-assisted suicide—which a recent survey reported outweighs physician-assisted suicide by far as a method for terminating life—and now includes mental illness and a worthless life, so long as the correct boxes are ticked. Emphasis is changing from a specific medical diagnosis to the importance of statutory control and oversight. In Belgium the process has been far more rapid, with statutory implementation in 2002 and a more recent inclusion of neonates and children. Again, the euthanasia option dominates by far. If physician-assisted suicide is seen as a Charter right, what are patients trying to say? That they may have the opportunity and the means to take their own life (terminally ill patients do not die with empty medicine cupboards), yet they prefer not to do so in the solitary confines of their bedroom and alone. They will request the presence of a physician, thereby legitimizing the act as well as giving it social and public acceptance. Or are patients confusing physician-assisted suicide with euthanasia—requesting legal sanction for suicide yet expecting a doctor to physically terminate their life on request? Anyone debating this issue, be it for or against physician-assisted suicide, needs to make sure the public understands the depth of the conversation.

—Kobus de Jager, MD
Victoria

Re: Forms, lies, and advocacy

I read your recent editorial [*BCMJ* 2014;56:213] with considerable interest because your experience has been almost identical with mine.

It seems to me that for those people who are truly disabled the disability pensions provided by the federal or provincial government are woefully inadequate. However, at the same time, there are clearly far too many people being awarded disability pensions on the basis of dubious evidence.

I always enjoy reading the editorials in the *BC Medical Journal* and look forward with interest as to what correspondence your most recent offering may stimulate.

—James K. Mackenzie, MBBS
Gabriola Island

We are writing in response to your editorial [*BCMJ* 2014;56:213] in which you claim some advocacy groups help their clients complete disability forms that are "dishonest and, frankly, fraudulent" and are trying to help their clients by "lying to have people collect unjustified income supplements."

While we share your view that it would be wrong for any organization to help people fraudulently obtain benefits, we are writing to provide you with a different perspective. The BC Coalition of People with Disabilities (BCCPD) has been assisting individuals with applications and appeals related to disability benefits for more than 25 years. We do not solicit clients. People come to us for a variety of reasons. They may have hearing or

visual limitations, mental illness, or cognitive impairments. Some simply do not have the use of their hands. Many physicians refer their patients to us because they know their patients do not have the skills needed to obtain the benefits that they are legitimately entitled to.

Some clients we serve may not have obvious disabilities. Conditions involving chronic pain, chronic fatigue, or posttraumatic stress disorder come to mind. Others who come to us are experiencing complications from surgery. Some have limited English language skills or may be illiterate.

Our doors are open to everyone who may need help.

Our advocates work hard to screen clients to determine if they may be eligible for the benefit they are seeking. Obviously some individuals lack insight about their limitations for various reasons, including mental health or cognitive issues. We expect doctors also encounter patients who are less than clear about their functional limitations. If someone tells an advocate they can't walk a block or climb two stairs and it later becomes clear that they can, it is hard to understand why anyone would then call the advocate a liar.

There are good reasons why most disability benefit programs require an opinion from a physician. Doctors are in the best position to provide objective medical evidence to verify an application for disability supports. Advocates help people describe their subjective circumstances but are not qualified to give medical opinions. However, many doctors have told us that they appreciate it when their patient comes to see them with a draft of a disability form that we have helped their patient complete based on the information they provide us with. If we use this strategy, we always explain clearly to the doctor that this is a guideline only and that we are not asking the physician to copy it for their evaluation of the patient. Doctors often tell us that they are swamped with paperwork and that our work with their patients saves them time.

Nonprofit organizations face intense scrutiny from their funders. Many of their advocates, including ours, are also supervised by legal counsel. With dwindling public resources, most nonprofits that work with people with disabilities are overwhelmed by the demands on their services. Your editorial gives the impression that you believe organizations such as ours are unaccountable and have nothing better to do than to help people drain the public treasury with fraudulent claims.

Nothing could be further from the truth.

—Jane Dyson
Executive Director, BCCPD
—Peter Beaudin
Senior Advocate, BCCPD

Two swindles

In the editorial "Forms, lies, and advocacy" [*BCMJ* 2014;56:213], DRR neatly skewers those medically qualified racketeers who unscrupulously support their equally unscrupulous patients' disability claims. It is, of course, axiomatic that behind every fraudulent disability claim there exists an equally fraudulent medical certificate. After all, *sans* this authentication such swindles would have no legs at all on which to proceed. DRR's piece ends with the author wondering why some physicians are willing to support such a fraud. This rhetorical wonderment is surely whimsical, the answer being patently found in the old Latin saw, *cui bono*. As always, cash is king. For some practitioners, the bar is simply set that low.

Elsewhere in the same issue of the journal, another dishonorable practice is described by Dr Keith White, chair, Patterns of Practice Committee [*BCMJ* 2014;56:223]. Dr White offers words of wisdom to doctors who indulge in this unethical practice. Dr White notes the Billing Integrity Program has seen an increase in the number of physicians engaged in this other swindle. While Dr White spells out clearly how such practice is a contravention of both the MSC Payment Schedule and the *CMA Code of Ethics*, he also counsels "Billing a $30 visit for a family member is not worth the risk of being audited," plus the warning "Physicians whose family billings exceed $1000 are now being reported to the College of Physicians and Surgeons of British Columbia." This is more of a watch-out article than a smarten-up one. Not so much, don't do this at all, but rather, don't do more than $1000 worth.

Every barrel of apples has a few bad ones, and the College's published disciplinary actions detail those of us who are found to be grievously wanting. DRR and Dr White highlight other patterns of practice that most doctors would find shameful, one of which is on the increase. Recently, I had occasion to draw the attention of one lawyer to the shady practice of another. The first lawyer acknowledged the legal profession has its share of bad apples. He quantified it this way: "There's froth at the top, dregs at the bottom, but the middle third is really quite sound." I wonder how our own barrel is presently divvied up.

—Gerard Ponsford, MBBS
White Rock

Re: Changes to medical staff privileging in British Columbia

On behalf of the Physician Quality Assurance Steering Committee, we write in response to Dr Mirwaldt's thoughtful letter published in the June issue [*BCMJ* 2014;56:219]. We welcome the engagement of the British Columbia College of Family Physicians and have collaborated with its representatives and those of the Society of General Practice to strike a panel that will develop the privileging dictionary for this discipline. We will meet with the panel several times

Continued on page 318

Continued from page 317

before the dictionary is completed in late October.

Our practice has been to use training objectives to define the privileges for a discipline and expect to do the same for family practice. Dr Mirwaldt's offer to share those objectives is welcome.

Most of Dr Mirwaldt's letter is concerned with the concept of currency. We fully agree that currency for family practice has to be approached from the perspective of the realities of the discipline. Indeed, each discipline we've worked with has found its own unique approach to currency. We also agree that currency is not a measure of competence and it is not intended to be. Assessing competence in established practitioners is a complex task that will take time and iterative study to do well.

Currency is that minimum level of activity below which a conversation needs to be had about comfort and support required to carry out a procedure. It is not an automatic disqualifier. Without clear criteria and a frame of reference most of us are uncomfortable initiating these discussions. Over the next few months our project's steering committee will approve a guideline for physician leaders and support staff to follow. The process is intended to prevent the abandonment of privileges by practitioners across the province. It will be supportive, fluid, and flexible and will seek to engage individuals in a discussion of what further training, mentoring, supported experience is required, if any, to allow the continued practice of the activity in the context of the service provided.

It is intended that dictionaries be reviewed post-implementation in pilot groups and again after reappointment in all health authorities. Following this piloting phase, it is likely dictionaries will be reviewed every 3 to 4 years to keep up with emerging changes in technologies and procedures.

Dr Mirwaldt speaks of the need to consider potential unintended consequences. We agree, and believe that we have done so, and are implementing this process in a way that will support the full engagement of family physicians across the province.

It's important to realize the health authorities of British Columbia have a mandate to deliver services to their populations. We share an interest with the BC College of Family Physicians in supporting physicians and other members of our medical staff and look forward to the work we are about to embark upon.

—Ted Patterson
Assistant Deputy Minister,
Health Sector Workforce Division,
Ministry of Health,
Chair, Physician Quality
Assurance Steering Committee
—Heidi Oetter, MD
Registrar, College of Physicians
and Surgeons of British Columbia