BCMJ
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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: Deprescribing medication for frail elderly

This is an important issue when it comes to working in geriatrics population [*BCMJ* 2014;59:436-441]. There is a tendency to continue to prescribe additional medication without careful evaluation of what the patient is on and whether it is still needed. Significantly untoward incidents can result from this polypharmacy and the drug interactions that ensue, at great cost to individuals, families, and the health care system.

When I trained as a family physician we learned well the lessons of monitoring medication use with flow sheets, at least one tool that can assist in preventing these disasters. Another was the home visit where a side trip to the patient's medicine cabinet was a useful venture. We can still ask patients to bring in all the medication they are taking, remembering also to ask about all the non-medication substances they are taking.

This article reminded me of a study carried out in the early 1980s by a couple of medical students, a physician in a neighboring town, and me. In our personal care home we had a practice of reviewing medications with the charge nurse every 3 months, at which time we decided what needed to be continued or changed. The neighboring town did not have this practice. Not surprisingly, the average number of drugs taken on a daily basis in the neighboring personal care home was double what was being dispensed where I worked: something like six to seven versus three to four.

This article did address the lack of funding to support such reviews. Indeed, the morbidity and mortality involved with overprescribing, including expensive evaluations and hospital stays, costs not only the individual and his or her family, but also our health care system. For the well-being of our geriatric citizens, as well as our increasingly resource-stressed health care system, it would behoove our Ministry of Health to fund such regular reviews in personal care homes. Community patients can have this done on a regular basis as long as their physicians have a system set up to do this.

—Lorne Brandt, MD
Richmond

Re: Physician-assisted suicide

In the October issue of the *BCMJ*, Dr Bill Cavers commented on physician-assisted suicide [*BCMJ*, 2014;56:381]. Physicians on both sides of this matter can certainly appreciate the import of the pending Supreme Court of Canada decision.

However, when considering this serious issue, it is vital that the stance of each side is accurately represented for proper understanding and clear communication. Dr Cavers presented a false dichotomy when he conflated the principled stance of doctors opposed to physician-assisted suicide (often sealed by oath) with "preserve life at all costs" while only those in favor are deemed to uphold the obligation to ease suffering, which is clearly within the rich and noble tradition of medicine.

Physicians and palliative care associations opposed to participation in patient suicide are not in favor of preserving life at all costs.[1,2] Withdrawal of medically futile care that is merely prolonging suffering is good medicine, but it is not the same as helping a patient commit suicide or inflicting death with a lethal injection.

Dr Cavers' phrase "an individual's right to an assisted death" is also problematic. By referring to it as a right, Dr Cavers is effectively marginalizing the convictions of those who see physician-assisted suicide as not only unethical, but fraught with well-documented dangers of expansion and abuse, as seen in Belgium and the Netherlands.[3,4] Once something is deemed a right, then there are difficulties in allowing freedom of conscience to deny that right. There are already circumstances where a physician's right of conscience is effectively denied, when activist groups demand purported rights.

Those who support physician-assisted suicide are seeking a service that could be, if legislated permissible, provided by someone outside the medical profession with minimal training. The hands of healers; however, should continue to be used to cure when possible, and to comfort always, with effective palliative care.

—Zoltan Horvath, MD
Langley

References

1. Canadian Society of Palliative Care Physicians. CSPCP position statement: The practice of euthanasia and assisted suicide, 2013. Accessed 10 December 2014.

http://www.cspcp.ca/wp-content/uploads/2014/02/EuthanasiaPositionStatementFINAL-June142013.pdf.
2. National Hospice & Palliative Care Organization. Commentary and resolution on physician assisted suicide, September 2005. Accessed 10 December 2014. http://www.nhpco.org/sites/default/files/public/PAS_Resolution_Commentary.pdf.
3. Lee Carter, et al v. the Attorney General of Canada and the Attorney General of British Columbia. Affidavit of Professor Etienne Montero submitted to Supreme Court of Canada 23 April 2014. Accessed 5 January 2014. www.epcc.ca/wp-content/uploads/2014/12/Affidavit-of-Etienne-Montero.pdf.
4. Hendin H, Foley K. Physician-assisted suicide in Oregon: A medical perspective. Mich Law Rev 2008;106:1613-1645.

Dr Cavers replies

As expressed in my response on this topic in the previous issue [*BCMJ* 2014; 56:475-476] we, as physicians, have very principled and strongly felt views on all sides of the issue of physician-assisted suicide. It is imperative that we fully debate all sides before making any determinations on its merit and future. I couldn't agree more with Dr Horvath's concluding statement about the hands that heal and the need for effective and accessible palliative care. And yet, there are those cases in which palliative care does not fully meet our patients' needs or wants.

—Bill Cavers, MD
Doctors of BC President

Re: Reconnecting physicians to primary maternity care

I read the article by Drs Ross and Armitage with some amusement [*BCMJ* 2014;56:458]. A partnership between Doctors of BC and the BC government has been formed to provide incentive for GP obstetrics! Is this the same government that decided many years ago to pay midwives three times as much for an uncomplicated delivery as a doctor would get for a complex one? I don't have access to detailed analysis, but in our community on the North Shore the decline in GP obstetrics began at about the same time as doctors learned they were undervalued, just as the overall decline in full-service family practice began when we were told we did not qualify for MOCAP. It is worth emphasizing; it is not just the dollars; it is the lack of respect that it signifies. I doubt if $1 million will bring that back.

—Mike Marshall, MD
North Vancouver

GPSC replies

Like Dr Marshall, I too remember the catastrophic hemorrhage of general practitioners from the practice of obstetrics when there was a political decision around the funding and privileging of midwives. What we are left with is a dedicated bunch of general practitioners who love to look after pregnant women and their offspring. A GP offers the best of both worlds—a philosophy of natural childbirth and the skills and knowledge to intervene or seek assistance from their obstetric colleagues in a timely manner.

The MC4BC program targets a variety of GPs, including those who are new to practice and want a bit of a confidence boost and ongoing mentoring, as well as those who provide the service in smaller communities and want to keep current with their skills.

I encourage all physicians who feel they would benefit from the MC4BC program to apply (http://gpscbc.ca/family-practice-incentive/maternity-care-bc).

—Shelley Ross, MD
Co-chair, General Practice Services Committee