“I’ll remain this sort of vegetable” 

When I read “Physician-assisted suicide from a patient’s perspective” in the February issue,¹ I was pleased that Canadian Family Physician had given copy to this important discussion and current topic. I thank Dr Jeff Sutherland for his important and personal contribution. My concern is the protection of those “not mentally capable,” including those with mental illness. I do not mean persons with schizophrenia or bipolar disorder but persons with major depression. There are millions of Canadians who are treated for this illness. Depression carries with it many “cognitive distortions” that might manifest by changes in concentration, forgetfulness, and impairment of executive function. These changes do not cross the line to have one rendered “incompetent,” but might influence understanding and the choices one makes.

A 40-year-old female patient whom I had diagnosed with major depressive disorder of moderate severity had returned to review her screening and bloodwork results, which were all normal. I suggested she begin taking an antidepressant. She said, “You can go ahead and treat me, Doctor, but I’ve pretty well resigned myself to the fact that I’ll remain this sort of vegetable the rest of my life.” Her statement was so powerful and genuine that I wrote it down verbatim in her chart. Six weeks later, when she had improved considerably, I read it back to her. She laughed out loud and did not remember making the statement nor what would have led her to make the assertion then. She continued treatment and her depression resolved completely. She remains well to this day. If she had begin taking an antidepressant. She said, “You can go ahead and treat me, Doctor, but I’ve pretty well resigned myself to the fact that I’ll remain this sort of vegetable the rest of my life.” Her statement was so powerful and genuine that I wrote it down verbatim in her chart. Six weeks later, when she had improved considerably, I read it back to her. She laughed out loud and did not remember making the statement nor what would have led her to make the assertion then. She continued treatment and her depression resolved completely. She remains well to this day. If she had requested physician-assisted suicide in the midst of her depression and if I had granted it, it would have been a great tragedy.

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Competing interests
None declared

Reference

More opioid and CPD discussion

In the January issue of Canadian Family Physician, Dr Moore’s letter furthering the discussion on mandatory continuing professional development (CPD) for opioid prescribing is not so much about whether or not to support CPD but rather who sponsors the CPD courses.¹ If the makers of slow-release opioids are the drivers, then that agenda will come through. Truth is, while we might have a crisis of opioid overuse and deaths, we also have a shameful lack of expertise in managing pain. Practitioners in Atlantic Canada might wish to avail of a balanced CPD through the Atlantic Mentorship Network for Pain and Addiction, which offers a course on safe opioid prescribing.

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Competing interests
None declared

Reference

Lifetime Prevention Schedule: a BC initiative

As I read the article “Update on age-appropriate preventive measures and screening for Canadian primary care providers” in the February issue of Canadian Family Physician,¹ I found it a pity that Shimizu and colleagues seemed to be unaware of the work that has been done in British Columbia (BC) over the past decade to develop the evidence-based Lifetime Prevention Schedule (LPS). To a large extent the fault lies with us, as we have not published in the academic journals. So as one of the initiators and as founding Co-chair (along with Sylvia Robinson) of the Clinical Prevention Policy Review Committee (CPPR), allow me to provide some basic information about this important work.

Our work began in 2007 because there was a plethora of recommendations from the Canadian and American task forces on preventive care but no means to prioritize them. It was clear that it would be impossible for a family physician to provide all the preventive services that were recommended in the time available.² Moreover, there was no policy on a systematic approach to organizing and providing a comprehensive set of clinical prevention services in BC (or elsewhere in Canada). I characterized our approach—perhaps somewhat unkindly, but accurately—as “random acts of kind

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