"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 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

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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
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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

prevention," an approach that I believe is still largely the case in most other provinces.

In the beginning, the CPPR adopted the following definition of *clinical prevention.*

> Maneuvers pertaining to primary and early secondary prevention (i.e., immunization, screening, counselling and preventive medication as defined above) offered to persons based on age, sex, and risk factors for disease, and delivered on a one-provider-to-one-client basis, with two qualifications:
>
> (i) the provider could work as a member of a care team, or as part of a system tasked with providing, for instance, a screening service; and
>
> (ii) the client could belong to a small group (e.g., a family, a group of smokers) that is jointly benefiting from the service.[3]

We included the 4 categories of clinical prevention services used by the US Preventive Services Task Force: immunization, screening, counseling, and preventive medication. However, as BC already had a comprehensive process for adopting an immunization schedule, we chose not to replicate that work, while acknowledging it as part of the prevention schedule.

The 2009 report of the CPPR[3] (this report is largely based on the results from several technical reports developed by H. Krueger & Associates Inc in Delta, BC, under contract[3,4]) asked the following 3 key questions.

- What is worth doing?
- What is the best way to provide what is worth doing? (To consider at the practice level.)
- What is the best way to organize, plan, and manage the system in order to do what is worth doing? (To consider at the system level.)

To answer the first question, we asked another 3 questions.

- What preventive services have been demonstrated to be clinically effective?
- What preventive services are likely to have the greatest effect on population health?
- What preventive services are most cost-effective?

The answer for the first question was based on category A recommendations from the Canadian and American task forces; to answer the second and third questions, we turned to the work of Maciosek and colleagues[5] who had developed an assessment method for prioritizing clinical prevention using estimates of the clinically preventable burden and the cost-effectiveness of the intervention. They very kindly shared their methodology and tools with us, allowing us to conduct the analyses for BC.

- *Clinically preventable burden* is defined as the total quality-adjusted life-years that could be gained in BC if the clinical prevention service were delivered at recommended intervals to a BC birth cohort of 40 000 individuals over the years of life that a service is recommended.

- *Cost-effectiveness* is defined as the average net cost per quality-adjusted life-year gained in BC by offering the clinical prevention service at recommended intervals to a BC birth cohort over the recommended age range.

Based on the results of these analyses, a limited set of recommended clinical preventive services was developed; this was called the *Lifetime Prevention Schedule*. While some attempt was made to answer the second and third key questions (how best to deliver and support these clinically effective, cost-effective services so they would achieve the expected significant population health effects), this is still a work in progress. What is clear is that a systematic approach is needed, that electronic medical records need to enable both physician reminders and patient recalls, and that many of the lessons learned from creating systematic approaches to chronic disease management are applicable to the systematic management of clinical prevention.

British Columbia has continued to pursue this important initiative. The LPS has been adopted and the criteria are used to examine any proposed new screening program and to support BC's decisions on screening services; a prevention fee was created for family physicians, and the LPS has been revised and updated; the revised version will shortly be released. The LPS, as well as the technical work that underpins it, is a state-of-the-art resource that deserves to be more widely known. Moreover, it could readily be adapted to other provinces that want to develop a clinical prevention policy, to ensure that all those who are eligible receive all the effective clinical prevention services that matter. This will benefit both the individuals and the wider society by reducing the burden of disease, reducing pain and suffering, and reducing the demand for and the cost of health services.

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Competing interests
None declared

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Response

We thank Dr Hancock for sharing the extensive work that he and his colleagues have done on preventive care. We have reviewed the *A Lifetime of Prevention* report.[1] We believe that cooperation between public health and family medicine on this important topic is needed, as prevention is often neglected in our health care system.

In our article "Update on age-appropriate preventive measures and screening for Canadian primary care providers,"[2] our aim was to create a simple-to-use tool that could be easily accessed to facilitate prevention and screening at dedicated preventive visits or opportunistically at other visits. When creating this tool, we reviewed multiple prevention guidelines as defined in our article. We developed our tool keeping in mind the national recommendations when appropriate, such as the Canadian Task Force on Preventive Health Care guidelines on cervical screening, to make this tool useful across Canada.

We invite Dr Hancock, colleagues, and any *Canadian Family Physician* readers who would want to have a discussion about prevention to meet at the upcoming Family Medicine Forum in Vancouver, BC, in November 2016. This would be a wonderful opportunity to promote a partnership between provinces and disciplines.

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Competing interests
None declared

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