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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: Assisted suicide vs end-of-life care

On 10 February 2014, André Picard's column in the *Globe and Mail* describes the case of Margot Bentley, whose explicit directions for how she wanted to have her life end were rejected. What a travesty of common sense this has become. A few days later I was heartened to see that the January/February 2014 issue of the *BC Medical Journal* had four items on the topic of end-of-life care.

As physicians we are often actively involved in helping our patients determine how they wish to end their lives, so there is greater pressure on us to sort out our thinking on this matter.

Fortunately, our position in society as God-like authority figures has diminished, yet the mantle is easily picked up by organizations—in the Bentley case, by the Maplewood Seniors Care Society and the Fraser Health Authority. The complexities of end-of-life issues need to be discussed openly, especially by the professionals involved in caring for the dying. Because of our active role in this matter, we tacitly confirm these as health issues, or, as is happening now, as bureaucratic/legal issues.

The core problem is a moral one. Though we may disagree with our patients' moral values, in most cases we can establish a working relationship and provide medical services without difficulty. If there is a sticking point we don't force our patients into our value system, nor are we obliged to use treatments that offend our moral values.

Society depends on a dynamic balance between the rights and responsibilities of the one versus the group. Dr Allan Donkin (*BCMJ* 2013;56:6) identified the inherent difficulties in resolving these differences and clearly stated his position along the continuum. My position leans more toward the individual. I believe the ultimate decision on how to die must stay with the person (or delegate) taking that journey. We agree with this sentiment by accepting our patients' requests to stop treatments, but their wishes are often deserted as patients reach the end of life.

Let us continue to broaden these discussions.

—William Gardner, MB, ChB
West Vancouver

Dr Donkin is to be commended for again raising the subject of assisted suicide. It appears to be getting more coverage in the media and needs more from within the medical profession as well. His thoughtful letter does, however, contain several basic errors of fact and logic.

The parallel to the suggestion that access to assisted suicide automatically causes us to feel guilty for liv-

ing when we have a serious illness that might shortly result in death is the suggestion that, because we have abortion legislation, all women—on learning they are pregnant—immediately face a guilt-ridden decision about abortion. Obviously abortion legislation has not had this effect. It has simply given us one more choice involving autonomy and personal rights. There is no logical reason to jump to the conclusion that assisted suicide legislation will pressure people to choose suicide, but it will give many the opportunity to think about it in the context of a dignified death when palliative solutions are not sufficient for their needs.

Of course, as Dr Donkin points out, caring needs to be held in high regard. And I think those doctors who support Dying with Dignity (such as myself—a member of the Advisory Council of Physicians) hold that philosophy as central. Part of caring is alleviating the many cases of terminal suffering, such as that which we saw publicly with Dr Donald Low and that which we have all seen in some of our patients.

Naturally, we need more stringent controls than those in place for animal euthanasia but, in all honesty, we are more caring, as a society, for our pets' suffering than we are for human suffering. Dr Derryck Smith covered some of the issues in his letter (*BCMJ* 2014;56:12,47), written as a plea for Doctors of BC to take a leadership role on this issue.

There is a need to also address Dr Donkin's factual and other logical errors. First, the article written by Dr Pereira in *Current Oncology*[1] is a great example of pseudoscience. Publication in a prestigious journal does not guarantee factual rigidity. A follow-up article[2] in the same journal debunks his claims in great detail, specifically the infamous slippery slope argument that refers to horrors in Europe. A slippery slope on any medical or ethical legislation is dealt with through legal checks and balances and careful planning. There have been many such issues in medical care and there will be many more (for example, stem cell research), which require ethicists, lawyers, and medical advisors to tease out implications and issues and revamp the solutions periodically. The authors conclude with regard to Dr Periera's article that, "his paper should not be given any credence in the public policy debate about the legal status of assisted suicide and euthanasia in Canada and around the world."[2] Incidentally, Dr Pereira's paper was used as expert witness testimony in the recent challenge to the Criminal Code prohibitions of assisted suicide and voluntary euthanasia in the Gloria Taylor case. This only goes to show how important it is to check sources, and sources of sources.

Dr Donkin's final paragraph, offered as the right solution, is simply his subjective solution. Slippery slope arguments are commonly used to oppose assisted suicide, as in the article referenced by Dr Donkin. The argument that palliative care must supplant all other discussions is the ultimate emotional argument and, as important as it is, it is not always successful in ensuring a dignified and comfortable dying process.

I would like to see sensible legislation on assisted suicide over the next few years (probably too late for me!) so that we have choices in Canada and more autonomy with regard to dying with dignity.

—John Dale, MD
Nelson

References

1. Pereira J. Legalizing euthanasia or assisted suicide: The illusion of safeguards and controls. Curr Oncol 2011;18:e38-e45
2. Downie J, Chambaere K, Bernheim JL. Pereira's attack on legalizing euthanasia or assisted suicide: Smoke and mirrors. Curr Oncol 2012;19:133-138.

Personal View continued on page 126

Continued from page 125

I agree with Dr Allan Donkin on the subject of assisted suicide. I would be opposed to this for all of his stated reasons and am also opposed to the killing of terminally ill patients for any reason, in kindness or otherwise. Although one feels sure that noble motives exist in the minds of some who take an opposing view, it is too easy for physicians and nurses to become convinced that what they are doing is right simply because the profession is viewed in a light of kindness. We are all well meaning, aren't we? There are a few in every population who may enjoy this power. We are all scarred in some way and that does not always reveal itself in medical school entry exams or in any other evaluation of that kind, I assume. We are a mix, let's face it.

Further, not only would patients become embroiled in this fad of early death because it is open to them or expected, the very standing of the physician as reliably trying to support life in a trusted environment would be eternally damaged by the acceptance of the idea. It does not matter how many physicians feel they or colleagues have already justly done it occasionally with a tap of the nose or a wink as an act of all-knowing kindness or convenience. Presumably they live comfortably with that. Of course the proponents suggest that each practice may simply form a cadre of suicidists on the register to help the public feel that their doctor is not one of them. But he is one of them—the profession.

Patients who like the concept of assisted suicide would likely not think this way if we had not failed to fully address the need for better palliative care resources.

In allowing this process the profession would smear itself as the Greek physicians did, leading Hippocrates and others to see that the two behaviors could not coexist without ultimate and all-pervading contamination of trust and honor. Do the proponents think that the College of Physicians and Surgeons and the legal system disallow sexual encounters with patients because we are generally against sex? It is clear that we need to feel reasonably confident that our spouses, children, and patients are safe when undergoing consultation and surgery. The subtleties of these situations, as Dr Donkin implies, are more profound than modish, superficial lifestyles may appreciate. The thin end of the wedge of progress has a thick end, and the destruction of our patients' only hope in our integrity is attached to this.

Add to this my feeling that some momentum in this movement is generated by budget arguments. Well, swallow the cost. Let's do what is right and put our effort and charity and integrity into good palliative care as an ethical profession. Improved mental health services would likely help a lot, too.

—Paul Champion, MBBS
Gabriola Island

Canadian National Breast Screening Study—flaws

The Canadian National Breast Screening Study (NBSS) should not influence decisions about screening mammography, neither for individuals nor on a policy level.

The recent *British Medical Journal* publication of the latest update on the NBSS is not new research. It was because of major problems with its design and execution that in 2002 the World Health Organization excluded the NBSS from analysis of the impact of screening mammography on mortality from breast cancer.

The biggest flaw of the NBSS was corruption of the randomization process. When women volunteered for the study, but before they were assigned to the control or study group, they had a thorough clinical breast exam. It is clear that women found

to have breast lumps were selectively put in the mammography group. The assignment was supposed to be done without knowledge of the result of the physical exam, but the names were written on open lists, making it possible for the staff to leave blank lines onto which they could then write the names of the women with lumps. The NBSS is the only mammography trial where more women died in the mammogram group than in the control group, not because mammograms don't work, but because more women with cancer were PUT into the mammogram group. Of women who died within 7 years because of advanced cancer, eight were in the mammogram group and only one was in the control group. This wouldn't have happened if the randomization process had been blinded.

Contamination of the control group was significant. In the control group, 17% of women aged 50 to 59 and 26% of women aged 40 to 49 had mammograms outside the trial. And some of them would have had cancer detected and treated but they were still counted in the control group. This added to the appearance that the death rate was similar between the two groups.

Mammography in this trial was poor quality; they used secondhand equipment to save money. The mammography unit used in the Vancouver Centre of the NBSS was 10 years old at the start of the trial. The false negative rate in the NBSS was worse than in studies done in the 1960s and 1970s.

In the NBSS, the average size of the cancers detected by mammography was 19 mm, only 2 mm smaller than those detected by clinical breast exam. Compare that to our screening program in British Columbia where 65% of cancers detected at screening are less than or equal to 15 mm, and 76% are node negative.

The Canadian Task Force on Preventive Health Care was unduly influenced by this trial. They balanced what they considered the benefits and harms of mammography and concluded that it should be done less frequently. By including the NBSS in their meta-analysis they mathematically reduced the demonstrated mortality reduction.

The Task Force overstated the harms: They considered it a significant harm to make women nervous when called back from screening and for some to have unnecessary biopsies. The vast majority of these are needle biopsies done with local anesthetic. Most women would choose those short-lived harms over being denied access to screening.

If women heed the bad advice of these authors we will soon see an increase in the average size of breast cancers, the rate of axillary metastasis, and the death rate.

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