

Ineffective and uncontrolled

“And what do *you* do?”

I dread being asked this question because my answer is often followed by the enquirer listing all of his or her recent symptoms in painstaking detail. However, because my mother taught me not to lie, I told the middle-aged woman sitting beside me on the airplane that I was a family doctor. This led her to share the story of her husband’s heartbreaking struggle with cancer, to which he eventually succumbed. After surgery, radiation, and evermore toxic rounds of chemotherapy, he was told that he had a few months to live. The woman went on to explain how they had seen a number of alternative health practitioners who gave them hope when all was lost and offered further treatment. Sadly, he lived the expected few more months despite shelling out thousands of dollars for these treatments.

I can understand patients and their families looking for alternatives when they are told nothing else can be done to prevent them or their loved one from dying. They grasp onto whatever therapeutic hope they

have left—rationalizing that the cost is small when human life is part of the equation. I’m sure many of you have patients who have gone to clinics in the US or Mexico, where they claim to be able to help terminally ill cancer patients. However, this woman’s husband was treated in my community with vitamin infusions, herbs, hyperthermia, and more.


I am sure many alternative practitioners believe in their treatments, but the fact is that they are profiting from terminally ill patients. I realize that oncologists and others also make a living taking care of cancer patients, but they adhere to evidence-based medicine and drug trials. It breaks my heart to watch families invest their savings in treatments that have little evidence to support their use.

It is a difficult conversation to have with dying patients and their families—advising them to discontinue these therapies—particularly when the alternative practitioner is advocating the opposite. I find it frustrating that there doesn’t appear to be any control over these groups, and

it makes me angry that I am powerless to stop it. If I were offering a for-profit treatment for terminal cancer without evidence of efficacy, I would be brought before the College in no time. These patients and families are already going through so much; they shouldn’t have to sift through this quagmire of unproven cancer treatments in addition.

By questioning the benefits and appropriateness of these treatments I am often accused of mudslinging, turf protecting, or worse. Surely, there must be some course of action for us to take. I am sure it’s a horrible thing to be told that you have run out of life-prolonging treatments. However, I think it would be better to focus energy on spending time with family and friends than delaying this process by getting involved in costly, ineffective therapies. I will continue to try to shield my dying patients from this practice, but I often feel powerless to stop it.

—DRR



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It's still not over, Debbie

I had been in practice for a few years, and had been involved in the management of quite a number of women with ovarian cancer, when “It’s Over, Debbie” appeared in *JAMA* in early 1988. In that anonymous essay, a gynecology resident described how, after being woken during a night on call to attend a distressed 20-year-old woman with terminal ovarian cancer, he (or she—it was never specified which) had administered an excessive dose of morphine. The woman died within minutes. From the tone of the essay, the resident seemed to feel that doing this was the only reasonable response to horrific suffering (the resident described the patient’s room as “a gallows scene”). But many of us felt that this was a disturbing rush to judgment and just plain wrong. The resident was tired, did not know the

patient, was not familiar with her circumstances, and interpreted the patient’s statement “let’s get this over with” as a plea to accelerate her dying. During residency we become familiar with the idea that patients die, but this familiarity should not mean that hastening death becomes just another management option. I found the resident’s hubris chilling.

Can a physician switch easily from efforts to maintain quality of life to a quick action that takes life away?

Needless to say, publication of this essay provoked a storm of responses, some praising the resident’s actions and many condemning them. Local authorities petitioned *JAMA*’s editorial offices with a view to prosecuting the author, but the editor of *JAMA* refused to disclose the author’s name. Nor was it known when this incident took place—or even if it took place at all. What publication of the essay did, though, was reignite discussion of euthanasia and physician-assisted death. Lawyers, ethicists, sociologists, religious experts, and physicians all weighed in, and the debate has continued—with some excellent and thoughtful opinions expressed in the *BCMJ* earlier this year. Just about all of us have opinions on the morality (and potential for legality) of physician-assisted death, and most of us are convinced that we’re right and those who think differently are wrong.

Earlier this year, the CMA released an update of its policy on euthanasia and assisted suicide. In the document the CMA confirmed that it was not opposed to palliative sedation or withdrawing or withholding life-

sustaining interventions when these were no longer wanted or indicated, but repeated its opposition to euthanasia and assisted suicide. However, the CMA subsequently softened its position to support physicians who follow their conscience “within the bounds of existing legislation.” Very shortly, the Supreme Court of Canada will hear arguments that the law banning assisted suicide is unconstitutional; the BC Supreme Court has already decided that it is, but the law in BC has not changed. Quebec, however, has very recently made physician-assisted suicide legal; the province has circumvented the federal law by specifying that their legislation is an extension of existing health services, which are a provincial responsibility. So the ground is shifting.

If the federal law changes, will physicians readily agree to assist? When the CMA canvassed Canadian physicians, 16% to 20% indicated that they would be prepared to participate in physician-assisted death if it were to become legal. But I wonder—when push comes to shove, how many of those 16% to 20% will have the nerve to make good on their intention? Can a physician switch easily from efforts to maintain quality of life to a quick action that takes life away?

As has been stated repeatedly, our efforts for the terminally ill should be directed ceaselessly and tirelessly toward maintaining their quality of life, with the aim of allowing an easeful death. Agreed, there are countless reports of terminally ill patients having a peaceful death by their own hand or with the assistance of a physician. But I am still haunted by the feelings I had when I first read “It’s Over, Debbie.” If I assist someone in taking his or her own life, I cannot possibly know—whatever the circumstances—whether it was the right thing to do. And there is no going back.

—TCR

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