Although you may not have noticed it, the ratio of male births to female births is dropping. Whereas the ratio used to be 105 boys to every 100 girls, there has been a measurable decline over the last 20 years (a loss of 2.2 male births for every 100 live births from 1970 to 1990). The experts are looking for an explanation for why this ratio, which used to be extremely stable, has changed. They cite older age of parents, environmental pollution, fertility drugs and so on. But maybe the explanation is more subtle and yet more profound.

We know that, in nature, the ecosystem maintains a remarkable stability. It is well documented that when certain species become overpopulated the size of their litters declines, and when their population is sparse, the size of their litters increases. This change can be quite remarkable, 2 to 3 times the number of live births in one cycle — whatever is needed to maintain the species.

For the human race, the ratio of 105 male births to every 100 female births was remarkable. Given the higher mortality rate among males, this ratio created almost equal numbers of males and females at the ages of reproduction.

However, things have changed. Survival in general has improved, especially at younger ages. The difference between the mortality rates among males and females, which until 1970 had always favoured females, has actually narrowed. Much of this can be explained by smoking habits. Deaths from accidental causes are down, especially, again, among young males.

Thus, were the natural world to continue to produce 105 boys for every 100 girls, we would have an oversupply of males in the reproductive ages, rather than an equilibrium. What was needed to compensate was a decrease in the ratio of male to female live births. And guess what? That is exactly what has happened!

Coincidence? I do not know. However, I do know that not everything in demography has an easy actuarial explanation, which is what makes the discipline so fascinating.

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Touched and troubled by Amy

I was most impressed — and touched — by the article "Learning from Amy: a remarkable patient provokes anguished debate about rationality, autonomy and the right to die" (*Can Med Assoc J* 1997;156:229-31), by Dr. Stewart Cameron. Her experiences clearly show what occurs when autonomy is disregarded. These are exactly the kind of events that no one should have to put up with. Surely, in appropriate cases — competent adults with a terminal illness, for example — physicians should be allowed to provide assistance in dying to those who have repeatedly requested it as a means of sparing them the last few days or weeks of suffering. Such a physician-assisted death can well be the last act of love, mercy and compassion, not unlike the service veterinarians provide for suffering animals. Anything else would prolong dying, not living. Physicians should no longer look upon death as a failure or defeat, but as the relief it is in this kind of situation.

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There are several troubling things about the decision to die recounted by Dr. Cameron. I especially agree with a statement in the article, "he also noted wryly that the current test of rationality was often concurrence with the opinion of one's physician."

I cannot help wondering whether the tone would be different if Amy was 27 or perhaps 17 rather than 77. I am concerned that this article was written by someone in family medicine, who had only a superficial knowledge of what was really happening with Amy, rather than by her psychiatrist, who had been able to spend some time with her. I cannot help wondering whether I am being sold the opinion of Cameron rather than the heart of Amy. What would this article have been like if someone had been able to get past her superficial defences to find out what was really in her heart?

This is the crux of the rush to grant people their "choice" to commit suicide: we are presented only with a very narrow, positive aspect of a person's decision to die. What about all of the other factors we do not hear about? What if a relative had been found? What if there was a concerned daughter, son or grandchildren who had lost track of Amy because of her delusional thinking? Why was she so isolated? Is that considered normal?

I wonder why Amy's first decision to "go swimming" was in a place where there were people in boats. Was there perhaps a deep longing to be rescued? And, somehow, the people in hospital who treated her sided with her "wish to die" rather than her deep longing to be rescued.

If any adult in our society really wishes to commit suicide, there is really nothing anyone can do to stop that person — we all have that choice. Patients who end up in the medical system are by that very fact requesting our assistance to help them out of a very difficult, painful and often poorly understood situation. It behooves us to ally ourselves with life, not with death.

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