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PHYSICIAN-ASSISTED DEATH: THE WRONG ISSUE

I am interested in the recent discussions about euthanasia and physician-assisted death (*Can Med Assoc J* 1995; 152: 1845–1852, 1855–1856). I believe they indicate that the practice of medicine has wavered far from its early ethics and has lost a great deal of its human touch.

Thanks to our great technology we are capable of great harm. We frequently prolong death instead of life. Once we start down the path of eager and aggressive therapy for a disease, it is very difficult to stop, turn around and choose a different path. It takes a brave physician to do so, at the risk of apparent failure and possible litigation, and a very brave patient to say No, I do not want that treatment, at the risk of alienating his or her caregivers.

Euthanasia is technology without humanity; science without art. In combination with society's failing value system, technology has made euthanasia a debate of our times.

I think we are debating the wrong issue.

We should not be asking, When is the time to help a patient to die? but rather, When is the time to stop fighting death? We can prolong life almost (but not quite) indefinitely with aggressive intervention, but we then bring people to the point that they dream longingly of death as an unobtainable goal.

Less aggressive treatment does not mean inferior care. Rather, real caring increases because medical personnel can no longer hide behind technology and must look instead at the person beyond the disease.

In the teaching hospitals where I trained, the fight against death was paramount. We were not taught the ethics of medical technology in a well-defined way. I would like to see an open discussion of those ethics to address the question, When should we stop?

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MURDER–SUICIDE A CRISIS, NOT AN ETHICAL ISSUE

The recent article "Murder–suicide involving BC doctor raises troubling questions about euthanasia" (*Can Med Assoc J* 1995; 152: 1855–1856), by Valerie Wilson, was ostensibly about euthanasia and Alzheimer's disease. It concerned a retired anesthetist 74 years of age who had Alzheimer's disease and was given a lethal injection by his wife and caregiver, who was 40 years of age and presumably in good health. She then committed suicide.

Apparently the couple had made a suicide pact out of "love" for each other. By what definition of love was the wife, Dr. Lorraine Miles, denied a long and meaningful life?

Dr. Miles was suicidal. To respect her decision to end both her life and her husband's suggests that physicians should help suicidal patients not to recover but to die.

The real tragedy is that a situational crisis was transformed into an ethical debate.

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INTEGRATING COMMUNICATION SKILLS IN MEDICAL EDUCATION

The three articles in the May 1, 1995, issue devoted to communications ("Communications research," by Dr. Patricia Huston, *Can Med Assoc J* 1995; 152: 1371, "Effec-

← For prescribing information see page 837

tive physician–patient communication and health outcomes: a review," by Dr. Moira A. Stewart, *Can Med Assoc J* 1995; 152: 1423–1433, and "Quality assessment of a discharge summary system," by Drs. Carl van Walraven and Anthony L. Weinberg, *Can Med Assoc J* 1995; 152: 1437–1442) appear as actions are being taken to improve both the teaching and learning of communication skills.

This letter is to inform readers of the action taken by the bodies responsible for undergraduate medical education in Canada and the United States. These are the Committee on Accreditation of Canadian Medical Schools (CACMS), which is responsible for the accreditation of undergraduate medical programs in all of Canada's 16 medical schools, and the Liaison Committee on Medical Education (LCME) in the United States, which participates in accreditation visits. Through representation on each other's committees, both bodies accredit Canadian medical schools. These bodies develop common accreditation standards, which are published jointly in *Functions and Structure of a Medical School*. CACMS is sponsored and funded by the Association of Canadian Medical Colleges and the CMA.

The Canadian representatives on the LCME sponsored a resolution to be integrated into these standards. The resolution was discussed at several LCME meetings, and the following text was approved on Apr. 5, 1995. (The same resolution will come before the CACMS at its next meeting in September 1995).

Communication skills are integral to the education and effective function of physicians. There must be specific instruction and evaluation of these skills as they relate to physician responsibilities, including communication with patients, families, colleagues and other health professionals.

Provincial licensing bodies report that the main complaints they receive result from a lack of communication between patients and physicians. Major adjustments in curriculum content, teaching methods and evaluation processes will be instrumental in improving physician–patient relationships.

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Rickets still affects Canadian children

Peter Wilton's article "Cod-liver oil, vitamin D and the fight against rickets" (*Can Med Assoc J* 1995; 152: 1516–1517) needs some amplification. Rickets is one of the oldest diseases, first described centuries before Dr. Francis Glisson's classic paper was published in 1650. The earliest known reference to rickets was by Soranus of Ephesus in about 100 AD. No account of the history of the disease is complete without mention of Mellanby, who first showed in 1919 that rickets is a nutritional disease, and of McCollom, who demonstrated 3 years later that rickets is caused by a deficiency of a fat-soluble dietary factor. Moreover, Palm is usually credited with the first report, published in 1890, that rickets is caused by lack of sunlight.

Unfortunately, rickets is still a health concern in some parts of Canada. The disease is seen with troubling frequency in native communities in Manitoba and northwest Ontario. At the Winnipeg Children's Hospital we saw 21 patients with rickets caused by vitamin D deficiency between 1989 and 1994. The patients ranged in age from 6 weeks to 2½ years, and all but one were native. Eight of 12 patients less than 6 months of age presented with hypocalcemic seizures, and one had an acute life-threatening episode. And these patients by no means indicate the extent of the rickets problem in central Canada;[1] they were merely the most acutely ill infants and children requiring treatment. We know of many other children with the disease who did not require admission to the children's hospital during this 5-year period.

The ability to synthesize vitamin D in the skin from sunlight is influenced by several factors, including latitude, season, the amount of skin pigmentation and the amount of clothing worn. In northern latitudes, sunshine during the winter is ineffective in producing vitamin D; in Edmonton, no vitamin D may be formed in the skin between October and March.[2] Because of geography and custom, children living in many northern communities synthesize little or no vitamin D; they therefore depend entirely on dietary sources. Since breast milk contains little vitamin D and cow's milk, which in Canada is fortified with the vitamin, is not used in some communities, vitamin supplements are the only alternative in these areas. The Canadian Paediatric Society has recommended vitamin D supplementation for all infants and pregnant and lactating women in northern communities.[3] Innovative strategies are needed to implement this recommendation.

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