breast-conserving surgery: the surgeon's advice and the patient's consent. All decisions about surgical treatment are the result of interaction between an individual surgeon and an individual patient. There are other interested parties, such as house staff, patients' families and other health care professionals who may play a role, but it is largely the patient who gives consent to have a particular procedure performed by a particular surgeon.

There is an unstated assumption in Dr. Neill A. Iscoe and colleagues' article that higher rates of breast-conserving therapy correlate with medical care that is up to date. I believe that a careful analysis of this assumption is in order. Given that the 5-year and 8-year survival rates are virtually identical for several modalities of treatment of breast cancer, consideration of one form of therapy as superior to another suggests that some other factors are present.

Whether these factors are economic, psychosocial or even political is unknown; thus, the results of the current study are significant only in a statistical sense. Although it is interesting to note that there are significant variations in therapeutic choices from one geographic region to another, I am somewhat alarmed that this kind of information is used as a "marker" in evaluating hospitals. Aside from the fact that hospitals have no policies regarding this kind of therapeutic decision-making, it appears impossible to determine from the present study exactly what is being measured (perhaps "political correctness"?).

May I suggest that the most important factor in shaping the surgeon's point of view is the locale in which his or her residency training was completed. Philosophies adopted during residency training programs influence the nature of one's surgical practice for decades. A dramatic example might be a surgeon who has trained in a setting in which the psychosocial impact of breast surgery is considered insignificant; at the other extreme would be a graduate of a training program in a large Canadian city, for whom issues of psychosocial adjustment, body image and feminist ideology assume profound significance. Such philosophic variables would certainly influence attitudes toward conservative surgery. The present geographic location of the surgeon's practice would have a relatively minor influence.

From the rural patient's perspective, the main argument against breast-conserving surgery is the prospect of spending 5 consecutive weeks 200 km or more from home and undergoing daily "high-tech" treatments in the relatively impersonal (and sometimes expensive) world of tertiary care in a major urban centre.

I would plead for breast surgeons to be involved in discussions of breast surgery. It is obviously beyond the authors of this study to appreciate the complexity of the scientific issues involved, not to mention the cultural, psychosocial and political elements.

Randy W. Friesen, MD, FRCSC
Prince Albert, Sask.

[Three of the authors respond:]

Dr. Friesen's letter sheds little light on the issues surrounding regional variability in the use of breast-conserving surgery.

Friesen indicates that the selection of a surgical procedure is a decision reached by the patient after receiving advice from her surgeon. The implication is that patient consent legitimizes variability. This is an unsupported assumption. Every practitioner (including the first author — an oncologist with a primary interest in malignant melanoma and other solid tumours) has faced the challenges of communicating difficult news and complex information to patients and then attempting to elicit their treatment preferences. The inadvertent miscommunication that occurs in doctor–patient encounters is well known.

Friesen opines that the surgeon's point of view is most closely related to the locale of training. Data were not available to test that hypothesis or to test the more plausible hypothesis that date of training was influential. Friesen specifically implies that training programs vary in the emphasis they place on the impact of mastectomy on body image and psychosocial adjustment postoperatively. We would be very curious, as doubtless would the profession and the public, to hear about any Canadian program that teaches that "the psychosocial impact of breast surgery is considered insignificant."

Having claimed that the current locale of the surgeon's practice would likely be of minor significance, Friesen immediately goes on to note that a major consideration in procedure selection from a patient's viewpoint might well be the distance to treatment centres.

We agree with Friesen that many factors influence procedure selection for a woman whose breast cancer has just been diagnosed. Leaving aside the rare occurrence of major coding errors by hospitals, the extent of variability observed implies that these other factors are distributed unevenly by hospital and region. Thus, we do not agree that the results are significant in only a statistical sense.

Friesen is concerned that this kind of information might be used as a "marker" for evaluating hospitals and, indirectly, the staff in them. Our report and others like it do not provide information about the quality of care in any particular region. What reports like ours do provide are signposts for local follow-up.

Like Friesen, we believe that the decision regarding a breast surgery procedure is one made by the patient in consultation with her surgeon. As we pointed out in our article, a variety of systemic factors, ranging from access to screening and early diagnosis to availability of radiotherapy facilities, can shape the decisions to be made. So will the surgeon's own beliefs and communication style. The impact of these diverse factors can

For prescribing information see page 877 →

only be addressed through cooperative multidisciplinary efforts.

Friesen implies that surgeons should be more involved in any analysis of practice patterns. We, too, would welcome their involvement. As the leaders of the Ontario Medical Association know, we have offered to work in support of any rigorous and systematic initiative by the general surgery community to pursue the issues raised in our study. No such initiative has materialized to date.

Neill A. Iscoe, MD, MSc, FRCPC
Vivek Goel, MD, MSc, FRCPC
C. David Naylor, MD, DPhil, FRCPC
Institute for Clinical Evaluative Sciences in Ontario
North York, Ont.

International workshop on medical ethics and human rights

As secretary of the Commonwealth Medical Association, which organized the international workshop on medical ethics and human rights as part of its project on the role of medical ethics in the protection of human rights, I welcome the opportunity to supplement Dr. John R. Williams' comments on Professor Charles L.M. Olweny's letter (*Can Med Assoc J* 1994; 150: 1381).

Representatives of the national medical associations of several developing countries actively participated in meetings of both the steering group and the working group of the project. Since Olweny's letter was published, a further stage of the project has been successfully completed with the pilot regional workshop, to which Williams refers in his letter, held recently in Kenya.

The purpose of that workshop, which was funded by the Ford Foundation and attended by representatives of the national medical associations of several African developing countries, was to ensure that the guiding principles on medical ethics prepared by our working group were entirely appropriate for medical practice in such countries. We were gratified to find that after some fine-tuning there was unanimous agreement that the principles covered all possible ethical contingencies.

Olweny emphasizes that human rights abuse is not peculiar to developing countries, and he refers specifically to an African charter of human rights. Not only was this charter the subject of a special session at the pilot workshop but also a leading African expert on the charter was flown in from Europe especially to address the workshop and to participate in the discussions.

The guiding principles on medical ethics are about to be published together with the briefing papers prepared for the working group. Doctors practising in Commonwealth countries are responsible for the medical care of 1.4 billion people — more than a quarter of the world's population — most of whom live in developing countries. The need for ethical guidance appropriate to conditions of medical practice in such countries has remained unsatisfied for far too long, and this important initiative has attracted considerable international interest.

The Commonwealth Medical Association is indebted to the CMA for facilitating funding by the Canadian International Development Agency of the meeting of our working group, and I am grateful for this opportunity to join Williams in reassuring your readers about Olweny's concerns.

John Havard, MD, LLM, FRCP
Honorary Secretary
Commonwealth Medical Association

Private medicine in Britain: Truth or opinion?

Are manuscripts accepted for publication in *CMAJ* edited? Caroline Richmond's article "Private medicine takes on the NHS [National Health Service] in Britain" (*Can Med Assoc J* 1994; 150: 1459–1460) should have been.

In her account of the tragic case of Ruth Silverman, Richmond calmly states that "if [Silverman] had been an NHS patient, she would be alive today." Readers should have been told whether this is Richmond's opinion or the verdict of a coroner's inquest. As well, they should have been told how many people on NHS waiting lists would not have died had they been cared for in private hospitals.

The glaring examples of malpractice in the NHS are ignored in the article, the blame being laid on "private-sector surgery." Malpractice can happen in the best university teaching hospitals.

Richmond further states that the British Medical Association (BMA) fee scale is "predictably" higher than those of the insurance companies. Without background information this is a gratuitous insult and, at the very least, biased "doctor-bashing."

Perhaps Richmond doesn't remember that the medical association schedules were for *minimum* fees, which, when the insurers (including government) took over, somehow became the maximum fees the insurers were willing to pay.

In short, Richmond adds to the current cacophony of politically correct propaganda that bashes money-hungry doctors and calls balanced billing "extra-billing" and "illegal," while government blatantly lays on its own user fees, deletes entitlements, shuts down wards and operating rooms, blames private hospitals for malpractice and suggests that government hospitals prevent malpractice. Richmond seems to imply that we should ban private care.

Manley Samuel Wolochow, MD, FRCPC
Richmond, BC

Ms. Richmond's brief account of my wife's death after she underwent routine hysterectomy understates the shortcomings of British private hos-