What price freedom?

Dr. Andrew A. Horn's letter "Dr. McCrae's expensive war medals" (*CMAJ* 1998;158[10]:1271) expresses a deplorable lack of awareness and sensitivity to the contributions and sacrifices made by 2 generations of Canadians in World Wars I and II. We owe these people a great debt for the peace and freedom we now enjoy. European war cemeteries contain the graves of more than 100 000 Canadian military personnel. The list of the dead contains the names of many of our professional colleagues, including that of Dr. John McCrae.

Medals are awarded by a nation to its service personnel for service in particular campaigns and for heroism beyond the call of duty. I find it sad that instead of the Canadian government or one of our medical associations, it was a private citizen who bought McCrae's medals to ensure that they would stay in Canada.

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Can we alleviate unnecessary stress?

The article "Undergraduate and postgraduate medical education in Canada" (*CMAJ* 1998;158[8]:1047-50), by Drs. Jean D. Gray and John Reudy, is informative but documents in a near-casual and certainly inadequate fashion recent fundamental and, from my perspective, detrimental changes to postgraduate education:

- the requirement that medical students decide at an early stage whether they wish to become family physicians or specialists
- the near impossibility of switching from one stream to the other (particularly for family physicians who may wish to become specialists)
- the change in licensure such that most specialists now write their Royal College of Physicians and Surgeons of Canada examinations near the end of the final year of training.

I disagree with the observation that "[t]his relative inflexibility [in terms of changes to a chosen career path] has resulted in small numbers of unhappy and stressed residents. . . ." My impression is that *many* medical students and residents are under stress because of this inflexible, rigid, even nonsensical system. The leaders of our profession have a responsibility to advocate changes that better permit young physicians to achieve their goals and to complete their training without this type of stress.

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Relieving suffering

I was much impressed by Dr. Elizabeth J. Latimer's article "Ethical care at the end of life" (*CMAJ* 1998;158[13]:1741-7) and her emphasis on the importance of adequate pain relief, even if this requires increasing the dose of morphine, which might lead to the patient's death (the so-called "double effect").

Dr. Latimer repeatedly stresses the importance of patient autonomy, which brings me to the case of the competent dying patient who wishes to be spared the last few days or weeks of suffering and asks for the doctor's help in getting his or her wish. How can such an often-repeated request for a last compassionate and merciful act be ignored by a physician who respects the patient's autonomy? If it is ignored, surely the dying, not the living, will be prolonged. We do not permit animals to "suffer to the end," so why insist on it with people?

Should it not be permissible to assist with the dying of those who suffer from a fatal illness, who have no hope of a reasonable lifestyle in the future and who say "enough is enough"?

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[The author responds:]

I read Dr. Dunn's letter with considerable dismay. My purpose was to describe in some detail what "ethical care at the end of life" actually means in clinical situations and to outline the positive, effective and proactive role that physicians must take in the relief of suffering. My intention was to describe what is ethical practice and what can be effective in helping patients and their families. If all seriously ill and dying patients, regardless of their disease, were to receive the type of care presented in my article, the present burden of suffering in our country and elsewhere would be greatly reduced.

Contrary to persistent popular belief, dying patients who are cared for attentively rarely request euthanasia or assistance with suicide, or, if they do, the desire for early death can be closely associated with treatable depression.[1] Surely it is our professional and moral responsibility to diagnose and treat the depression, provide a supportive relationship and affirm the worth of the patient.

Debates about this subject have taken far too much of the stage in recent years in Canada — at our professional meetings and in the popular press. A special Senate com-