[The author responds:]

Dr. Gutowski is troubled with Amy's story, and that was exactly the purpose of publishing it. He is appreciating some of the feelings we experienced at the time. Amy was a singular woman. She presented us with substantial challenges that evoked considerable soul-searching.

It is fair to suggest that the patient really had a deep longing for assistance and that her first suicide attempt was a cry for help. However, careful examination of the details makes this appear unlikely. She was repeatedly offered aggressive medical treatment, palliative care and psychiatric help, all of which she unequivocally refused.

Gutowski refers to my "superficial" knowledge of the patient. As hospital department chief, I participated in many of the deliberations. I reviewed the records and spent hours interviewing those who cared for her, including the family physician who had established a good relationship with her. Almost all of the principals mentioned in the story reviewed the manuscript, checked it for accuracy and offered supplemental material. I can therefore assure Gutowski that my understanding of the details is not superficial. I also suggest that a family physician with a continuing relationship with a patient can have as deep an understanding of patients and their social context as a consultant psychiatrist can gain from even several sessions.

Gutowski implies that Amy's death was somehow facilitated by her physicians and that her care was managed in a cavalier fashion. The article makes clear the extent of advice, assistance and support offered to her. Although it may be desirable to "ally ourselves with life" when possible, we do not have the right to overrule the wishes of competent people, even if we feel they have made a bad decision. Although it is appropriate for a professional caregiver to suspect that a wish to die is not rational and must therefore be based on a mental illness, it remains our belief that this was not the case with Amy.

The details around Amy's last days were reviewed by our hospital's ethics committee at the time, and it felt the decision to release her was reasonable. More recently, her case was formally discussed during an interdisciplinary rounds. Her caregivers, the ethics committee, 2 medical bioethicists and a representative from the coroner's office were present. We reviewed details not covered in the article or available at the time of her death, including a "psychological autopsy" from the medical examiner. There was again no suggestion that her treatment was wanting. Although we continue to debate the issues and wonder "what if," I am convinced that Amy received compassionate and appropriate care to the fullest extent possible.

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The CPP and mental disabilities

I congratulate Nicole Baer on her article "Disability payments continue to climb: 'Tell us what you see, not what you think,' CPP tells MDs" (*Can Med Assoc J* 1997;156:61-4). Canada Pension Plan (CPP) disability benefits are a very complex issue. I appreciate the final comment attributed to CPP administrators, "just tell us what you see — don't tell us what you think."

However, I am alarmed by the accompanying article, "Too much money wasted on frivolous applications for CPP disability benefits" (*Can Med Assoc J* 1997;156:65-6), by Dr. Samuel Shortt. He focused too much on physical disability and appeared to ignore mental illness and resulting handicaps. Further, one of his comments — "there are also applicants who have no medical disability but rather social handicaps such as substance abuse" — displays an ignorance that could be dangerous to his patients. Physicians' lack of appreciation for problems related to substance abuse and dependence leads to a lot of patient abuse. Not every patient suffering from substance dependence requires CPP disability benefits, but there are patients with a primary diagnosis of substance dependence who have other concurrent problems such as chronic pain or anxiety disorders that prevent them from obtaining gainful employment. There are some substance-dependent patients who suffer recurrent relapses because of inability to handle day-to-day life and work stressors. I encourage Shortt to approach his patients in a more open manner and to appreciate the biopsychosocial and spiritual aspects of the illness. Focusing too much on biophysiology leads to shortsightedness.

Raju Hajela, MD, MPH
Addictionist
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[The author responds:]

It is gratifying that Dr. Hajela found my article on CPP disability payments so thought provoking. However, I am puzzled by both the eccentric interpretation he has given it and the strangely sanctimonious tone of his letter.

Let me clarify the points he has raised: I drew no distinction between physical and mental disability nor did I accord priority to either, and I made no statement to suggest that significant substance dependence is not a

medically legitimate and potentially pensionable disorder.

The latter subject, I suspect, may point to the covert agenda in this exchange. Addiction medicine is a fledgling area of medical specialization that is actively striving for wider recognition. It does itself no service, however, by launching intemperate attacks on imaginary enemies.

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A fine piece of writing

I just read Dr. Maria Hugi's account of her experience with breast cancer ("Surviving breast cancer: an emergency physician faces the fight of her life," *Can Med Assoc J* 1997; 156:397-9). It may be the best piece of medical journalism I have ever read. Her complete candour about all of the effects cancer had on her life — professional, marital, sexual and parental — and, by implication, on her spirit, is utterly refreshing. Her terse, matter-of-fact style made the unspoken anguish all the more apparent, but only because of this candour.

Rare indeed must be the physician who can discuss the sexual side effects of hormonal therapy, attend a doctor-bashing support-group meeting and admit that her clinical skills had atrophied, and do so in a public forum. Rarer still must be physicians who can read this and not see their next patient with cancer, or even anxious about cancer, in a different light.

I suppose, ideally, that the fact that this story came from a fellow physician should not increase its relevance to us, but I believe that it does, immensely. Perhaps this is because so much of what I see as a neurologist is not what it seems, even regarding physical signs. I sometimes have difficulty believing something is the way it is until I find a physician, presumably as objective about medical matters as I am, who is experiencing it. I have thought, since my oncology rotation during internship, that the experiences of physicians with cancer could be a vast source of information about the human side of cancer. Time and again, while administering heroic chemotherapy in what was fairly obviously the last weeks of a person's life, I have asked myself, "Is this what a knowledgeable physician, a truly informed person, would want?" I still do not know the answer to that question, but I do know a whole lot more about humanity's gritty survival instincts, hinted at in Hugi's article. Thoughtful physicians who read it cannot help but improve or renew their appreciation for the experiences of patients with cancer, particularly women with breast cancer.

Keep up the good work, Dr. Hugi (and I love the name of your support group, "Treasure Chests").

John C. Hostetler, MD
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Received via e-mail

Residency-exchange programs

The resident-selection season is upon us again, and the process cannot help but provoke some thoughts on some of its apparent flaws. Canadian medical graduates are increasingly apprehensive about obstacles to returning to their home province if they choose to train elsewhere. As a result, they are often making choices that may have more to do with family and geography than with education.

One approach that may partly answer new graduates' worries would be to modify the current resident-training system to allow and encourage trainees to spend at least 1 or 2 years of training in another Canadian program. If this idea were widely accepted, an exchange between programs could develop so that there would be no alteration in the total number of residents in any program. For example, residents in anesthesia at the University of British Columbia could do their third year at the University of Toronto, with Toronto residents in anesthesia moving to Vancouver.

If the present resident-selection process and educational system are allowed to continue without change, there will likely be a great diminution in exposure to different ways of thinking and working as well as in opportunities to engage in special learning experiences. The increasing geographic narrowness of medical education in Canada should be examined not only for its impact on residents but also for its implications for the medical profession and the quality of health care in this country.

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Radical choices in mastectomy

I found the editorial "A surgical subculture: the use of mastectomy to treat breast cancer" (*Can Med Assoc J* 1997;156:43-5), by Dr. Adalei Starreveld, to be a bit patronizing.

Of course all surgeons are aware that partial mastectomy and irradiation is the treatment of choice in most cases of breast cancer, but not all of us practise in communities near radiation-therapy centres.

When confronted with the need for 6 weeks of treatment out of town away from dependent, often elderly, relatives — not to mention dependent