



suffering, even if such therapies may shorten life. This satisfies society's laws and morality and is consistent with ethical medical care.

This is in stark contrast to euthanasia, which is a deliberate act to end life. Relief of suffering does not enter into the definition and may or may not be a goal. The distinction between good palliative care and euthanasia (active or passive) or physician-assisted suicide is clear and important, not just semantics. Considerate palliative care respects the guiding philosophies of patient care and medical ethics, above all by protecting individual autonomy and dignity while doing no harm. The aim is to allow the inevitable. Most important, good palliative care makes euthanasia and assisted suicide unnecessary.

Palliative care is hard to do well. Society has allowed a mechanism to evolve that works extremely well when applied correctly. The cases mentioned by Gorman do not cry out for euthanasia or legislative and medical change, but they do demonstrate what can happen when people do not do their jobs properly. These cases show the importance of continued medical education, awareness and proper training. As Gorman suggests, euthanasia can have "adverse social consequences" and would put the profession and society on a slippery slope.

Peter Lovrics, MD
Hamilton, Ont.

Reference

1. Gorman D. Active and passive euthanasia: the cases of Drs. Claudio Alberto de la Rocha and Nancy Morrison. *CMAJ* 1999;160(6):857-60.

To screen: perchance to treat

The strong impression one gets from reading the article by Pierre I. Karakiewicz and Armen G. Aprikian in the *CMAJ* prostate cancer series¹ is that serum prostate-specific antigen (PSA) screening is beneficial. Their initial teaching point reads "Early detection of prostate cancer is of utmost importance, given that localized disease represents the only curable stage." Does the evidence support this view, or is it a manifestation of wishful thinking?

On the basis of the authors' own words, I would submit it is the latter. Karakiewicz and Aprikian admit that there is no direct evidence that treatment of prostate cancer is effective, but they also state that "definitive studies to prove that early detection and treatment lower the mortality rate have been initiated" (emphasis mine). Surely the studies referred to were designed to determine *whether or not* early detection and treatment lower mortality.

At present no one knows whether PSA screening for prostate cancer is beneficial. This should have been the initial teaching point in the article.

Kenneth G. Marshall, MD
London, Ont.

Reference

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Rooted in the country life

In their study of the effect of rural background and clinical rural rotations on subsequent practice location, Mark Easterbrook and colleagues failed to address a factor that is intuitively important in determining whether physicians choose to practise in a rural area: influence of the physician's spouse.¹ Practice location has been shown to be determined in part by the spouse's preferences.²⁻⁵ A 1985 study showed that, in addition to physician background (including the size of the community where the physician grew up and the size of the physician's high school graduating class), the background of the physician's spouse was a significant factor affecting recruitment and retention of physicians in rural practice.² Rural communities appear to appeal to spouses who are from rural communities themselves and who find job opportunities in the area.^{2,5}

I am a rural physician, and my wife is from a rural area. We have been very happy living in small communities in Canada. Future studies should take spousal factors into account to determine what rural communities can do to

become more attractive to prospective physicians and their spouses.

Adam Poradzisz, MD
Edmonton, Alta.

References

1. Easterbrook M, Godwin M, Wilson R, Hodgetts G, Brown G, Pong R, et al. Rural background and clinical rural rotations during medical training: effect on practice location. *CMAJ* 1999; 160(8):1159-63.
2. Leonardson G, Lapierre R, Hollingsworth D. Factors predictive of physician location. *J Med Educ* 1985;60(1):37-43.
3. Woodward CA, Ferrier BM. Career development of McMaster University medical graduates and its implications for Canadian medical manpower. *CMAJ* 1982;127(6):477-80.
4. Riley K, Myers W, Schneeweiss R. Recruiting physicians to rural practice. Suggestions for success. *West J Med* 1991;155(5):500-4.
5. Anderson EA, Bergeron D, Crouse BJ. Recruitment of family physicians in rural practice. *Min Med* 1994;77(7):29-32.

[One of the authors responds:]

I thank Dr. Poradzisz for his comments on our article.¹ We looked at the relative effects of a physician's exposure to rural communities, comparing the effect of having grown up in a rural community with the effect of exposure to rural communities during training. We found that prior residence in a rural community was a stronger predictor of practice location. As Dr. Poradzisz points out, the origins of the spouse have also been shown to be an important factor. Since we also had these data we looked at the effect of having a spouse from a rural community (10 000 or fewer people) and found that it was an independent predictor of a physician deciding to practise in a rural community (crude odds ratio 31, 95% confidence interval 1.5-6.4, $p = 0.003$). This does not change our results, but rather it strengthens the finding that rural background influences rural practice decisions.

Marshall Godwin, MSc, MD
Department of Family Medicine
Queen's University
Kingston, Ont.

Reference

1. Easterbrook M, Godwin M, Wilson R, Hodgetts G, Brown G, Pong R, et al. Rural background and clinical rural rotations during medical training: effect on practice location. *CMAJ* 1999; 160(8):1159-63.