Why quackery thrives

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When Danielson, Stewart and Lippert’s article (see page 1003) was first received by CMAJ last year the editors feared that the subject of unconventional cancer remedies might not be sufficiently original to appear in the pages of the journal. After all, quackery and “miracle cures” have been with us since time immemorial. Nevertheless, today, when we supposedly know more about body function, disease and the practice of medicine than ever before, why do ill and even healthy people resort to unproven and ineffective remedies propounded by charlatans?

Certainly, as Danielson and colleagues point out, it is not surprising that cancer patients and their loved ones might be driven in desperation to try unproven remedies. After all, what is there to lose? On its own the word “cancer” evokes strong emotions from most of us. Its diagnosis is bound to drive some to grasp at any straw, however flimsy. This is especially understandable in patients with acquired immune deficiency syndrome, the latest victims of unscrupulous healers. But the use of unconventional remedies and preventive nostrums is not confined to the tragically ill. The curative or preventive powers of various unproven compounds, along with advertisements that barely stay within ethical bounds, greet us almost daily in newspapers and magazines. Such compounds obviously sell, otherwise the ads would disappear. The tragedy is that, for the terminally ill, useless remedies offer false hope in exchange for large amounts of money and ultimately greater suffering. For the healthy, unproven nostrums at best waste money and time and at worst may promote illness, even death.

Two solutions seem evident. The first is education. For far too long health education has been given little emphasis in primary and secondary schools. It is nonsensical to me that students graduate from high school with little more than the most elementary education in health; they should know at least as much about their bodies and disease as they do about mathematics and history. If our people are to participate intelligently in the management of their own health, they must have the knowledge and skills to ask the right questions and seek the correct answers. Health education is not the sole responsibility of the traditional health professions: it must be built into provincial curricular guidelines and provided by well-informed health educators.

The second solution lies within the essential skills of all health workers, especially physicians. Danielson and colleagues rightly point out that physicians must be sufficiently well informed about unproven health remedies to discuss them objectively with their patients. They should also be sufficiently open, tolerant and empathetic to counsel their patients with sensitivity. In other words, they must recognize what charlatans have known and used for centuries. Physicians who spend time with their patients, emphasize their patients’ individuality and recognize their patients’ right to be involved in their own treatment are more likely to establish rapport than those who are too authoritarian and proscriptive. These skills must be carefully nurtured, and their achievement should be sought within the undergraduate and postgraduate training programs of all physicians.

Medical students cannot develop the skills of listening and understanding and counselling on the wards of tertiary care hospitals and under specialist instructors who are concerned more with the intricacies of disease than with the needs of the patient. It is imperative that medical schools revise their undergraduate and postgraduate programs to reflect that competent medical care involves more than high technology and specialty or subspecialty training. Physicians must also learn what all quacks have known for years: it is not enough to
should doctors kill patients?

Peter A. Singer, MD

I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room. . . . I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. . . . I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing rate slowed even more, then became irregular, then ceased. . . . It’s over, Debbie.¹

It’s over, Debbie”¹, an anonymous first-person narrative account of active euthanasia published in the Jan. 8, 1988, issue of the Journal of the American Medical Association (JAMA),¹ poses a serious ethical question: Should doctors kill patients? Although the publication of this article also raises questions of journalistic and legal ethics (the anonymous article may not be a true account, and

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JAMA has been embroiled in a First Amendment battle to protect its source), these concerns should not be allowed to obscure the fundamental question of medical ethics posed by the Debbie case: physician-mediated killing. At issue here is not the withholding or withdrawing of life-sustaining treatment or the administration of analgesia in response to pain but, rather, the direct injection of a lethal substance with the intention of causing the death of the patient.

Patient killing by doctors (proponents want to call it “active euthanasia” or “mercy killing”), a practice that, until recently, would have been dismissed as a sick joke or a shameful relic of recent history, has come to be viewed as a defensible public policy option. In the Netherlands an estimated 5000 to 8000 patients have been killed by doctors,² and the so-called Humane and Dignified Death Act,³ which would legalize lethal injections by physicians, may be on the November ballot in California.

In light of these disturbing developments elsewhere, doctors in Canada must take a firm stand. Physician-mediated killing is bad for patients, doctors and society, and the only justifiable stand toward active euthanasia can be summarized in one word: abhorrence. Physician-mediated killing is bad for patients, who stand to gain little and lose much. Patients gain the option to be directly and immediately put

have information; the real skill of caring for patients is in recognizing and understanding their needs and concerns.

Years ago — I cannot remember exactly when — US medical educator Dr. George Miller pointed out that physicians should not rail against unorthodox practices and medicines but should study carefully what charlatans do to persuade their patients that an unorthodox medical treatment is better than the best that medical science has to offer. What he was saying, of course, was that the failure of patients to act rationally in the face of incurable or perplexing illness is not so much a result of patients’ irrationality as it is of physicians’ lack of skill in communicating effectively.

It was with these thoughts that the editors of CMAJ decided that Danielsen and colleagues are right to point out again that the business of unconventional remedies, particularly in cancer therapy, still thrives. It is now up to physicians and medical educators across Canada to recognize their responsibility to help medical students and residents acquire the skills and knowledge to counsel their patients effectively. Those skills will not erase quackery and its catastrophic consequences, but they will go far to ease the suffering of a large number of tragic but misguided patients.