NO HOLDS BARRED Margaret McCartney

The fight is on

Cancer Research UK (CRUK) wants people to "show us your fight face" by posting their selfies on Twitter to raise money for its "life-saving research to bring forward the day when all cancers are cured." In Glasgow, earlier this year, an advertising agency working for the Beatson Cancer Centre declared on billboards, "Be full of hope. Be courageous. Be ready to fight," adding that it was "determined to beat cancer."

CRUK says it has a "war chest"[1] for research funding. Many patient-bloggers on its website describe "victories" over cancer. The charity describes research that "recruits viruses for cancer battle," under the heading "Let's beat cancer sooner."[2] The advertising agency for CRUK's fun runs said that it aimed to transform them "from a gathering of women in pink" to an "army who run, dance, and sing." The agency said lines like "Cancer! We're coming to get you" and "Oi! Cancer! You. Me. Outside. Now" were "designed to have cancer quaking in its rubbish boots."[3]

How many patients fear that they are not "a fighter" and will be damaged by that kind of pressure?

Twitter
@mgtmccartney

Military metaphors appeal because they make grey shades distinct and the "enemy" clear. But they are also prejudicial. Susan Sontag pointed this out in her *Illness as Metaphor* in 1978; we have not made much progress since. The late journalist John Diamond wrote, "My antipathy to the language of battles and fights has . . . everything to do with a hatred of the sort of morality which says that only those who fight hard against their cancer survive it or deserve to survive it—the corollary being that those who lose the fight deserve to do so."[4] His view is also evidence based: a "fighting" coping style is not associated with improved survival.[5]

It's astonishing, then, that Diamond's view has gained so little respect among fundraisers. It's one thing to accept individual patients' use of war metaphors for themselves; it's another to encourage their widespread use.

And what of the potential harms? How many patients fear that they are not "a fighter" and will be damaged by that kind of pressure? One series of interviews found that patients thought that doctors had promoted a "positive attitude" but that this left little room to express fear, shock, or sadness.[6]

Many types of cancers are not curable; thousands of people are living with "the enemy." In the unlikely event that "all cancers are cured," humans will still die. No one needs to be told what their attitude to illness should be—least of all by advertising agencies.[7]

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

Provenance and peer review: Commissioned; not externally peer reviewed.
Competing interests and references are in the version on thebmj.com.
Cite this as: *BMJ* 2014;349:g5155

BMJ BLOG OF THE WEEK Paul Teed

Is medical opinion shifting towards support for an assisted dying law?

Paul Teed is a junior doctor in A&E. He is a member of Healthcare Professionals for Assisted Dying

The Times recently published findings from a new survey conducted by Medix, which asked 600 doctors various questions on assisted dying, assisted suicide, and euthanasia.

While the majority of doctors were against a UK change in law to allow physician assisted suicide and/or euthanasia when asked the question in broad terms, a majority of respondents also believed that there would be grounds for physician assisted euthanasia if a patient had a terminal illness.

Other surveys and research make clear that medical opinion includes a wide range of views on assisted dying, and that there is no unanimous verdict from the profession. However, this particular survey shows that doctors draw a clear line between assisting a patient who is dying and one who is not. In that sense, the surveyed doctors are similar to the general public, who show much more support for allowing assisted dying for people who are terminally ill, mentally competent adults.

This view is in line with the current proposals that are being scrutinised by the House of Lords, after Lord Falconer's Assisted Dying Bill passed its second reading debate in July. The bill would only allow assistance to die for patients who have a prognosis of six months or less to live, and who have been assessed as mentally competent by two independent doctors.

Perhaps the most revealing question from the recent Medix survey was when doctors were asked: "What system do you think should be in place to safeguard terminally ill patients who want an assisted suicide and [to] safeguard doctors who may be prepared to help them?" More than half (57%) of doctors wanted legislation in place that would allow the practice within stringent safeguards and national guidelines. Only 21% did not want legislation under any circumstances, and even fewer (12%) wanted a criminal law prohibiting the practice—the legal context we currently operate in.

Doctors have signalled that it is time to stop ignoring this issue and to work out how best to safeguard assisted dying

What this survey says to me is that many doctors are unhappy with the current opaque legal situation, where even discussing these issues with a patient may be breaking the law. It makes sense that doctors who come face to face with these issues will want an alternative to the current system, which operates behind closed doors, and which causes suffering for many terminally ill people—leaving families and medical teams feeling helpless. Indeed, the survey reported that just under a third (29%) of the doctors questioned had been asked by a patient to assist them to die.

Doctors have signalled that it is time to stop ignoring this issue and to work out how best to safeguard assisted dying. As Lord Falconer's bill moves to committee stage in the autumn, at which point the safeguards will be examined, it is clear that it is a question of how, not if, we change the law on assisted dying.

Is it ethical to hire sherpas when climbing Mount Everest?

A medical ethical approach may be useful, but the jury's still out, writes **Emily Largent**

The Everest climbing season that has just ended was marred by the worst accident in the mountain's history. On 18 April 2014, 16 Nepalese sherpas died in an avalanche, and subsequent climbing expeditions were cancelled.[1 2] The deaths of men from poor communities, hired to perform dangerous tasks for the sake of mountain climbing, provoked controversy.[3]

I used data on deaths above base camps from the Himalayan database,[4] and definitions from a prior study.[5] The aggregate risk of death for sherpas during a climbing season was 0.8% between 1922 and 2013. Including the recent disaster, 73% of all sherpas' deaths resulted from objective hazards (avalanche, ice-fall collapse, crevasse fall, or falling rock or ice[5]) (see the figure and table on thebmj.com).

The question of whether it is acceptable to pay porters to assume risks for the benefit of others is an extreme variant of cases—common in medical ethics—where compensation and assumption of risk coincide. Consider debates about the sale of vital organs, paid gestational services, and material incentives for participation in clinical studies. Five concerns that routinely arise in these debates are those of adverse risk-benefit ratios, undue inducement, coercion, exploitation, and effects on potential safety measures. How sound are these concerns in the context of Everest?

Firstly, is the aggregate 0.8% risk of death in each climbing season "worth it" to the sherpas, given the benefits? A high altitude sherpa can earn up to $5000 (£3000; €3700) a season; a porter at lower altitudes earns substantially less.[6] This pay, even for high altitude guiding, would not justify assuming severe risks for most people in developed countries. However, compare it to Nepal's average annual salary of $700,[6 7] and consider how much risk many sherpas and their families would encounter by not climbing Everest—by remaining unemployed or accepting hazardous work elsewhere (for instance, many Nepalese have travelled to Qatar for dangerous work helping to build World Cup stadiums).[8] One remorseful climber worried, "My passion created an industry that fosters people dying."[9] Whether this worry is founded depends on how much being a porter elevates sherpas' net risk in life. If working on Everest leaves the net risks unchanged, for example, then indulging rich climbers' passion does not "foster people dying" any more than it prevents people from dying.

A high altitude sherpa can earn up to $5000 a season . . . this would not justify assuming severe risks for most people in developed countries

Undue inducement exists when the offer of payment makes decision processes less rational, and resulting decisions are not consistent with the agent's settled values and aims.[10] We lack evidence that payment to sherpas creates cognitive distortion. Money clearly induces impoverished guides, but perhaps not unduly so. If sherpas are fully informed about the consequences of their choices, in light of their limited alternatives, they may make a perfectly rational choice to work on Everest.

Coercion is usually thought to occur only when one person implicitly or explicitly threatens another with harm in order to obtain compliance.[11] Even if sherpas have no reasonable alternative except to work on Everest,[9] they have not been coerced because they have not been threatened with harm. The remorseful climber admitted to experiencing the "guilt of hiring somebody to work for me who really had no choice."[9] Although the mere offer of employment cannot—by definition—coerce, it is less clear if, in "no choice" situations, offers violate some other right to autonomy.[12]

Exploitation occurs when one person takes unfair advantage of another's unfairly bad background conditions. By this definition, wealthy climbers are exploiting sherpa guides. However, this is mutually advantageous exploitation. The employment agreement makes both parties better off than they would be without it. Few Western expeditions would make it to the summit without a sherpa, and sherpas gain financially. Although wealthy climbers can shift risk to sherpa guides cheaply only because the sherpas lack decent employment alternatives, wealthy climbers are not personally the source of this background injustice. That is, they did not cause the income inequality, and it would be worse for many sherpas not to be thus exploited. It is an open and difficult moral question as to what, if anything, is the problem with mutually beneficial exploitation. So the correct policy response to this exploitation is not obvious.

The ethics of employing sherpas on Everest are complex. The solution that would be best for everyone is probably to make climbing Everest as safe as possible. Given the difficulty of predicting and avoiding objective hazards, however, it might be impossible in practice to improve safety greatly. Insofar as there is much demand to climb Everest and sherpas are essential to successful ascents, the sherpas could "exploit" this demand to claim higher wages and insurance payments than they currently do. Might increased compensation be perceived as a sufficient benefit to offset risk and therefore drive down investment in safety measures (a "crowding out" effect)? Perhaps. But higher insurance payments could also force Western guides and the Nepalese government to take risks to sherpas more seriously.[9]

It remains unclear whether it is ethical to hire Everest sherpas under existing conditions. However the close connection of the relevant considerations to mainstream medical ethics provides a framework for approaching this problem.

Mourning the 16 sherpas who died in April

Emily A Largent is PhD candidate, Program in Health Policy, Harvard University, 14 Story Street, 4th Floor, Cambridge, MA 02138, United States elargent@fas.harvard.edu

Competing interests: None declared.

Ethical approval: The Institutional Review Board of the Massachusetts General Hospital approved this study.

I thank Nir Eyal, Harvard Medical School Center for Bioethics and Harvard School of Public Health Department of Global Health and Population; Richard Salisbury, University of Michigan (retired); and Paul Firth, Department of Anesthesia, Critical Care and Pain Medicine, Massachusetts General Hospital.

Provenance and peer review: Not commissioned; not externally peer reviewed.

References are in the version on thebmj.com.

Cite this as: *BMJ* 2014;349:g5113