On doctor’s orders

The editorial in the Jan. 25, 2000, issue of CMAJ accurately captures the concern that Wayne Gretzky’s advertisement for an osteoarthritis medication legitimizes symptomatic treatment at the expense of primary prevention.1

There is another significant issue that arises from this endorsement by Gretzky. The text of the advertisement has Gretzky stating that he is taking medication on “doctor’s orders.” This blanket assertion of subservience strikes at the heart of a healthy patient–doctor relationship based on partnership, information and trust. Gretzky does all of us, patients and doctors alike, a further grave disservice by acceding to “copywriters’ orders” to perpetuate a stereotypic cliché.

Jim Ruderman
Family physician
Toronto, Ont.

Reference

Prenotification in cases of death at home

I appreciated the article by Veena Guru and colleagues on the response of paramedics to terminally ill patients experiencing cardiac arrest.1 However, I am not convinced that the development of an out-of-hospital do-not-resuscitate (DNR) protocol for paramedics is the most effective way to address these challenging situations. Rather, provincial legislation regarding health care directives can provide a uniform approach for all health care providers and the general public.

In 1992 Manitoba adopted the Health Care Directives Act, which outlines the process of producing an advance health care directive and defines the protection from liability that exists if treatment is withheld while acting “in good faith in accordance with the wishes expressed in a directive.”2 Such legislation obviates the need for separate policies for paramedics, nursing staff and others who must deal with a cardiopulmonary arrest in a patient for whom an advance directive outlining DNR wishes exists.

In Manitoba we also do not require a physician to pronounce death in a patient who has died at home when death was the expected outcome of an advanced terminal illness. A physician involved in caring for the patient must notify the chief medical examiner and the funeral home in writing about an anticipated death at home. When death occurs, the patient is taken to the funeral home and the physician can sign the death certificate in the office or hospital.

Together with an advance health care directive outlining a DNR request, this prenotification step effectively addresses the dilemma of resuscitation of the terminally ill patient at home, as long as supporting legislation exists. These very difficult circumstances need not be made more so by adherence to resuscitation policies in clearly inappropriate circumstances, against the wishes of patients and families.

Mike Harlos
Palliative care
St. Boniface General Hospital
Winnipeg, Man.

References

[Two of the authors respond:]

We appreciate and support the perspective offered by Mike Harlos. In addition to paramedics, others who may encounter this situation are firefighters and, in the near future, lay responders who are trained in public-access defibrillation. “Good faith” liability protection that is broad in scope would better serve societal needs and permit a more uniform response to out-of-hospital expected deaths. The Manitoba solution may serve as a template for change in Ontario.

All out-of-hospital programs of which we are aware rely on the availability of a written DNR request, yet we found that 70% of DNR requests were verbally expressed. A recent survey of our basic life support paramedics suggests that only 44% were comfortable with a verbal DNR order.1 Therefore, the success of such programs requires that physicians consistently engage patients and their caregivers in discussions about end-of-life issues, including advanced directives.

To complement the link between the treating physician and coroner’s office, there should also be a link that is unique to emergency medical services (EMS). The responding paramedic should not have the responsibility of deciding the veracity of a DNR request if the EMS system is inadvertently activated. Instead, the patient’s directive should be registered with the EMS system so that paramedics can receive notification of a verified DNR request prior to arriving at the patient’s residence.

Society has determined that the autonomous individual (or the individual’s advocate) has the sole right to make decisions regarding personal care. Ultimately, the out-of-hospital needs of the patient at the time of death should dictate the design of the system. Unfortunately, in Ontario, the converse is true today.

P. Richard Verbeek
Laurie J. Morrison
Division of Prehospital Care
University of Toronto
Toronto, Ont.

Reference

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“Sorry, doc, I forgot all about that”

I have intermittently been reading the conclusions from the Canadian Consensus Conference on Dementia.1 The thoroughgoing effort of Christopher Patterson and colleagues to manufacture concrete from Jello has provided me with considerable amusement during breaks in my current attempt to practise rational medicine with limited resources in rural Africa.

I have a comment related to recommendation 25: “Primary care physicians should notify licensing bodies of concern regarding competence to drive … unless the patient gives up driving voluntarily.” Until the end of 1997, I worked as a primary care physician and advisory physician at 2 long-term care facilities in London, Ont. From my Canadian practice experience, the recommendation should have been that “primary care physicians should notify licensing bodies of concern regarding competence to drive … even if the patient gives up driving voluntarily.”

Promises to give up driving voluntarily are subject to erosion by the genuine or conveniently exaggerated effects of short-term memory deficits: “Sorry, doc, I forgot all about that.” My usual policy was to approve of the patient’s wise decision to give up driving voluntarily but to tell him or her that I was required to inform the Ministry of Transportation anyway, just to keep everyone honest.

I never received an adverse reaction to this strategy; when I didn’t use this approach, however, I sometimes encountered awkward situations involving practical inconvenience (including personally having to disable vehicles and having to confiscate driver’s licences) and obvious potential medicolegal problems.

If ever the recommendations are revised, I would appreciate it if the committee would take into account my two cents’ worth.

James D.F. Harris
Brong Ahafo, Ghana

Reference

[One of the authors responds:]

James Harris’ comments are duly noted, and he is absolutely correct in stating that physicians in Ontario and other provinces are required to inform the Ministry of Transportation if there is a concern about driving safety. His observations about drivers “forgetting” not to drive are also most reasonable.

We do plan to update the recommendations at regular intervals, although this will not occur for several years at least.

Christopher J.S. Patterson
Department of Medicine
McMaster University
Hamilton, Ont.

Tea for two (reviewers, that is)

I have again been reading “Tea with Sir William Osler” by Sir David Weatherall.1 You solemnly say, “This article has been peer reviewed.” Who does a peer review of a delightful fantasy by a Regius Professor of Physic? Other Regius professors?

The reviewers missed one statement. Near the top of page 839, Sir David refers to “the marketplace-orientated health care system of North America.” This is incorrect. The Canadian health care system is based on government funding.

It makes me wonder: I can see the object of peer review for scientific papers, but what about for a splendid flight of the imagination? Is this type of review a sort of imprimatur from a holy office? A statement of correctness?

W. Harding le Riche
Professor Emeritus
University of Toronto
Toronto, Ont.

Reference

[Editor’s note:]

The article was inadvertently sent to 2 intrepid Oslerians, who graciously went where no reviewer has gone before. Our admission of this fact was also inadvertent.

Alternative therapies

The argument expressed in John Hoey’s editorial, “The arrogance of science and the pitfalls of hope,”1 was disappointing and unconvincing. Surely there is more reason for medical scientists to be alarmed by the apparent toleration, even acceptance, of alternative medicine than their frustration because of inadequate research funding. Should we not be critical of evidence supported only by testimonials and the claims of commercial concerns? The scientific
method, with its emphasis on disinterested investigation, careful analysis of data, conservative scepticism and consensual agreement, is the best method human beings have for approaching the truth.2

Hoey is incredibly naïve to think that there must be merit in alternative therapies because those with “a higher level of education” use them. Education (it is sad to admit) does not guarantee the ability to think critically and to use an informed scepticism in considering claims for the effectiveness of treatments.

It is misleading to refer to scientific medicine as “the establishment.” This term connotes some rigid ideological position whereas the scientific method has revealed, not just in medicine, a continually changing reality through revisions and self-correction.

If patients are “taking control of the agenda” regarding their treatment, let them do so. But let us not dignify treatment that is completely unsupported by scientific evidence with a medical endorsement. The best physicians can do is to inform patients of the lack of valid evidence supporting claims for alternative treatments (with a few exceptions) and to try to instill in patients an enlightened scepticism. I recommend to many patients The Wellness Letter published by the University of California at Berkeley. Contrast the sceptical (not negative) attitude toward alternative treatments in this publication intended for the lay public with the CMAJ articles criticized by Ian Tannock and David Warr.3

This editorial would have been bad enough coming from any physician. Coming from the Editor of CMAJ it makes me sad and embarrassed to be a member of the Canadian Medical Association.

Paul C.S. Hoaken
Psychiatrist
Bath, Ont.

References

[Editor’s note:]

Owing to an editorial oversight, this letter was not published in 1999 as scheduled.

Overnight dialysis

In June 1968, a colleague and I reported the case of a 14-year-old malnourished girl with end-stage renal disease who was dialysed daily, except Sunday, for 8–14 hours overnight.1 She had an excellent response, went home on this regime and eventually received a transplant. In October of the same year, we described our experience with 22 patients on home hemodialysis, 20 of whom were dialyzed 10 hours overnight 3 times weekly with the patient asleep for most of the procedure.2 This regime was initiated by groups at the Royal Free Hospital in England3 and in Seattle.4

My question to Andreas Pierratos, the author of “Nocturnal hemodialysis: dialysis for the new millennium,”5 is this. To which millennium was he referring?

Michael Kaye
Nephrologist
Hudson, Que.

References

[The author responds:]

I agree that the Tassin regimen of long dialysis 3 times a week is well known and inspirational. I believe that the systematic study and programmed application of the long and frequent dialysis regimen (nocturnal hemodialysis) will make it the preferred dialysis modality for a large number of patients. By the end of this year, 60 to 80 patients will be receiving nocturnal hemodialysis in Ontario, and a faster growth is anticipated in the future. This indeed makes it the most exciting dialysis modality in the new millennium.

Andreas Pierratos
Nephrologist
Humber River Regional Hospital
Toronto, Ont.

The journey through the ICU

As a neurosurgeon who deals with critically ill patients every day, I read a recent article by Deborah Cook and colleagues with interest.1 Upon reflecting, I felt that understanding of the reasons why advanced life support is withheld, provided, continued or withdrawn in the ICU could be enhanced by using an alternative metaphor: that of the ICU stay and its attendant use of technology as a journey.

At times the journey is complete by the time the patient arrives in the ICU. At other times, however, the journey through the ICU becomes a trip through uncharted waters, and in these cases the ship has no power against the ravages of nature.

In this context, medical technology may be viewed as one means of taking the journey. The withdrawal of support may be viewed as halting one means of transportation, while its continuation may be considered a decision to carry the traveller — the patient — forward. When technology is withheld, it may be considered a means of travel that the traveller cannot or chooses not to use.

Other modes of transportation are possible for journeys. This might be the reason why some patients have positive outcomes in the course of their illness that cannot be explained by contemporary western medicine.

On the journey through the ICU, there are many travellers. They are all affected by the trip, whether they consciously realize it or not. In a journey,
the travellers may make decisions on the means of passage they will take on the basis of their best intentions to reach a destination.

Michael Cusimano
Neurosurgeon
St. Michael’s Hospital
University of Toronto
Toronto, Ont.

Reference

A fine old country doctor

I read Edward Ralph’s editorial on Powassan encephalitis with interest. Powassan is a small community 35 km south of North Bay, Ont. A family doctor, R.H. Dillane, practised there for more than 50 years, and he diagnosed the disease that became known as the Powassan virus.

He referred the patient to Toronto and told the specialists at the Hospital for Sick Children how the child had contracted the disease. The specialists and researchers agreed with his diagno-

sis and then named the disease the Powassan virus.

RH, as he was known, never sent bills. He practised 7 days a week. He made house calls. In winter, he would travel with team and cutter. He never made much money. One year, when many doctors were away at the war, he delivered 233 babies in a house in town with the help of a nurse. He was highly regarded as an excellent diagnostician. It was said that, with little more than a history and physical examination, “he could just smell the problem.”

A local newspaper once published a photo of a doctor who was retiring from practice and commented that he had delivered 1000 babies. RH had a good chuckle over that one. “Heck,” he said, “I had a 1000 deliveries for which I never got paid.”

How nice it would have been if this disease had been called the Dillane virus in honour of the fine old country doctor who discovered it.

William J. Copeman
Family physician (retired)
Beaverton, Ont.

Reference

Correction

Owing to a production error, the reference footnotes are missing from the text of Christopher Doig’s recent commentary. The corrected text is available on eCMAJ (http://www.cma.ca/cmaj/vol-162/issue-3/issue-3.htm).

Reference