

Who determines the course of a patient's treatment?

In his review of Benjamin Freedman's *Duty and Healing: Foundations of a Jewish Bioethic*, David Novak refers to Freedman's consideration of the issue of informed consent.¹ To say that physicians have a duty to inform patients of their reasonable options (leaving aside the lack of specificity of the term "reasonable") does not mean that patients have the right to determine the course of their own medical treatment. Patients certainly have the right to choose from among treatment options of equal value that are consistent with their goals; they also have the right to refuse all options. However, they do not have the right to dictate to their physician how they will be treated, as so many patients try to do nowadays, coming to the office laden with Internet printouts and magazine articles.

Freedman obviously had greater faith in the wisdom of patients than I do. Novak says that Freedman "speaks of the patient as 'a responsible steward of his or her own body' and of patients as 'prudent caretakers.'" The prevalence of obesity and smoking and the general lack of physical fitness in Canada force me to conclude that this statement represents the triumph of Freedman's idealism over empiricism.

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Reference

1. Novak D. Reading Freedman [book review]. *CMAJ* 2000;163(5):577-8.

Jehovah's Witnesses and artificial blood

As a medical adviser for the Associated Jehovah's Witnesses for Reform on Blood, I would like to challenge some statements made by Zenon Bodnaruk in his response¹ to John Doyle's letter regarding Jehovah's Witnesses and artificial blood.² Bodnaruk states that our

Web site (www.ajwr.org) "purports to present the position of Jehovah's Witnesses." This is incorrect. The site does not represent the position of Jehovah's Witnesses in general, but rather the dissenting views among Witnesses regarding this controversial policy.³

Bodnaruk is also not completely correct in saying that "individual members make their own personal decisions with respect to fractions of blood components" and that this is "the long-standing position" of the religion. Official church publications show that the use of serum was prohibited by the church from 1964 to 1973, the use of clotting factors by hemophiliacs was prohibited until 1978 and the use of albumin was forbidden until 1981. More details of the history of the blood policy are available at our Web site, with references to Watchtower Society literature. The total reversal of the policy surrounding the use of hemoglobin in only 2 years, as reported by Doyle,² raises further concerns about the ever-changing nature of the policy.

The Associated Jehovah's Witnesses for Reform on Blood does not disagree with the blood-conservation strategy used by so-called bloodless programs. However, the bloodless medicine Bodnaruk and the Watchtower Society are advocating is not just a blood-conservation strategy. They fully expect members to lay down their lives when all alternatives to blood transfusion are exhausted. Bodnaruk is again disingenuous in ignoring the fact that the "life-saving blood conservation techniques" he advocates do not save the lives of many Witness patients who could otherwise survive if blood transfusions were used as a last resort.

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References

1. Bodnaruk ZM. Jehovah's Witnesses and artificial blood [letter]. *CMAJ* 2000;163(5):496-7.
2. Doyle JD. Jehovah's Witnesses and artificial blood [letter]. *CMAJ* 2000;163(5):495-6.

3. Elder L. Why some Jehovah's Witnesses accept blood and conscientiously reject official Watchtower Society blood policy. *J Med Ethics* 2000;26:375-80.

Military MDs know where their duty lies

While I applaud Heather Kent for bringing the problem of post-traumatic stress disorder in members of the Canadian Forces into public view,¹ one of the statements in her article disturbed me. Psychologist Marvin Westwood suggests that military physicians are obliged to report psychological symptoms.¹ This is simply not the case. The principle of patient-physician confidentiality applies for both military and civilian physicians. I am not allowed to report diagnoses to the superiors of a member of the Canadian Forces; all I am obliged to report are occupational restrictions relating to a member's illness.

If someone was suspected of suffering from or was diagnosed with post-traumatic stress disorder, they would likely be at least temporarily restricted from participating in other peacekeeping missions. The Canadian Forces would also ensure access to specialist medical and psychological assessment or treatment. Although some may fear career repercussions from a temporary inability to serve overseas, it is surely more important to prevent further potentially traumatic exposures to the realities of modern peacekeeping. "First, do no harm" is a tenet we take very seriously. Further, a diagnosis of post-traumatic stress disorder does not mandate release from the Canadian Forces. The decision to release or retain a member is based solely on his or her functionality; diagnoses are not revealed or considered.

I hope that physicians encountering members of the Canadian Forces who may have post-traumatic stress disorder do not leave military physicians uninvolved in the care of these patients. We have resources such as regional occupational trauma stress support centres that can provide expert and expedient help. And please do not contribute

to any unfounded suspicions about where our duty lies. As physicians, it rests with the interests of our patients.

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Reference

1. Kent H. BC physicians help peacekeepers fight their demons. *CMAJ* 2000;163(9):1183.

Correction

The prevalence rates displayed in Fig. 2 of a recent article by Mark Tremblay and Douglas Willms were incorrect.¹ The corrected figure appears on this page. All sample sizes from the National Longitudinal Survey of Children and Youth in the article are weighted. The corrected prevalence of

overweight among boys increased from 15% in 1981 to 35.4% in 1996 and the prevalence of overweight among girls increased from 15% to 29.2%. The prevalence of obesity in children tripled over that period, from 5% to 16.6% for boys and from 5% to 14.6% for girls.

Reference

1. Tremblay MS, Willms JD. Secular trends in the body mass index of Canadian children. *CMAJ* 2000;163(11):1429-33.

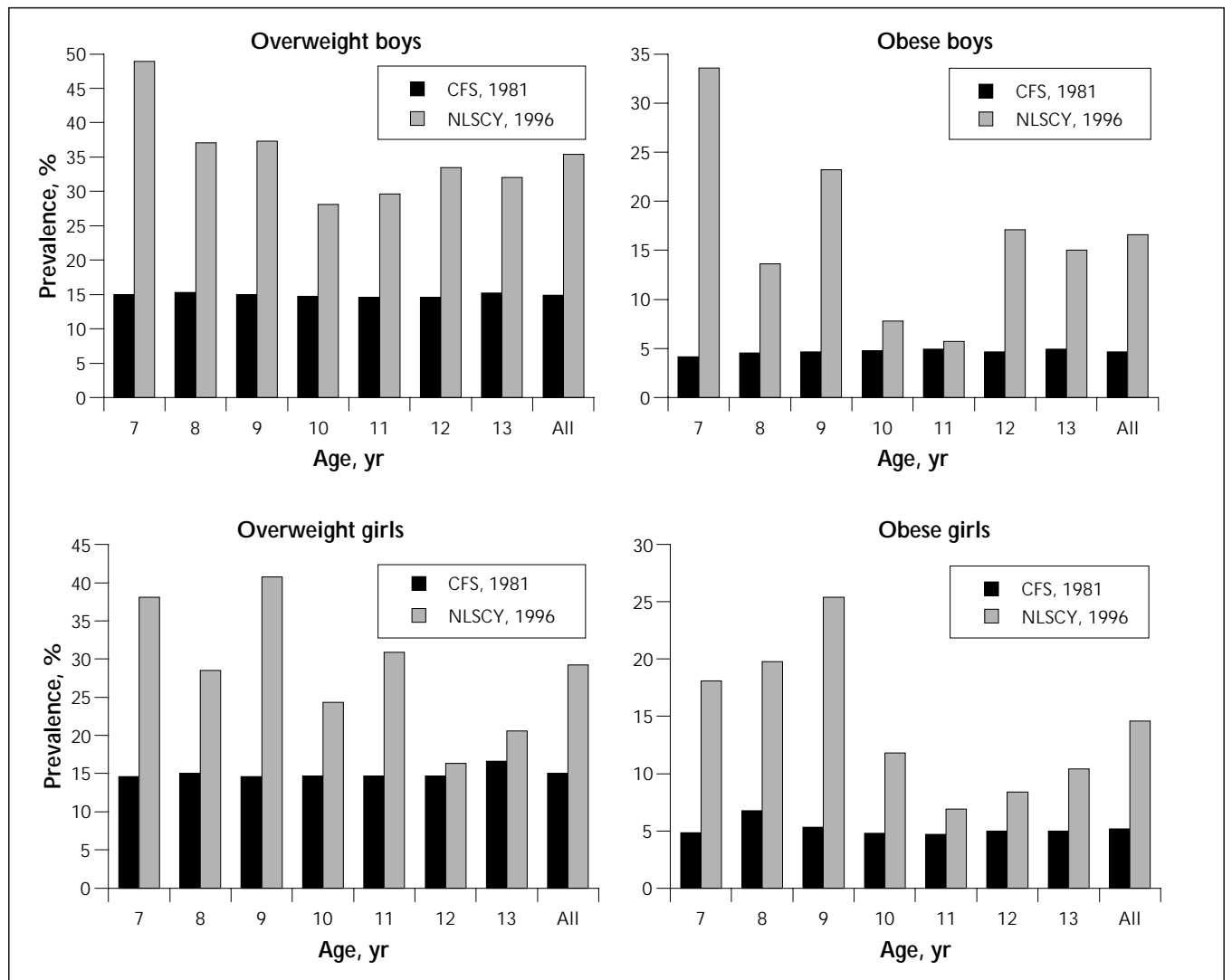


Fig. 2: Prevalence of overweight (> 85th age- and sex-specific percentile) and obesity (> 95th age- and sex-specific percentile) using the 1981 Canada Fitness Survey data as baseline for boys and girls aged 7–13 years.