"the constitutional freedom to one's religion" but noted that as is the case for other human rights, society's affirmation of religious freedom is not absolute. Just as one cannot seize on freedom of speech to yell "Fire!" in a public place, one cannot muster freedom of religion to command "never withhold my medical care" in a public health care system.

In fact, the very first sentence of the Charter of Rights and Freedoms makes it abundantly clear that one's freedoms are not absolute: it reads that one's freedoms are "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."[2] In many cases, including Samuel Golubchuk's, there are reasonable limits to medical treatment beyond which there lies only medical futility. Jewish or Christian, Muslim or Hindu, no matter what one's faith, it is the fallacy of freedom of religion as absolute and trumping secular medical judgment and ethics that our editorial rejects.

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Competing interests: See www.cmaj.ca/misc/edboard.shtml.

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1. Attaran A, Hébert PC, Stanbrook MB. Ending life with grace and agreement [editorial]. *CMAJ* 2008;178:1115-6.
2. *Canadian Charter of Rights and Freedoms,* Part 1 of the *Constitution Act,* 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c11 [Charter].

DOI:10.1503/cmaj.1080063

Prehospital and in-hospital advanced life-support

The recent article by Ian Stiell and colleagues on prehospital care was excellent.[1] However, as we question the value of prehospital advanced life-support we also need to determine whether in-hospital emergency advanced life-support makes a difference in patient outcomes. Those of us who have provided advanced cardiac life-support and listened to unsubstantiated claims about its benefits over the years must be aware that the use of bicarbonate, bretylium, calcium, vasopressin, amiodarone and many other drugs has probably done more harm than good.

It is important to practise evidence-based medicine and thus the use of prehospital advanced life-support should be validated, but we must also recognize that the role of emergency physicians in both advanced trauma life-support and advanced cardiac life-support has never been validated in an outcome study either.

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Competing interests: None declared.

REFERENCE

1. Stiell IG, Nesbitt LP, Pickett W, et al. The OPALS Major Trauma Study: impact of advanced life-support on survival and morbidity. *CMAJ* 2008;178:55 1141-52.

DOI:10.1503/cmaj.1080066

Corrections

In the Practice article "Toward a more effective approach to stroke: Canadian Best Practice Recommendations for Stroke Care,"[1] the URL in the footnote of Box 1 should have been included as www.canadianstrokestrategy.ca.

REFERENCE

1. Lindsay P, Bayley M, McDonald A, et al. Toward a more effective approach to stroke: Canadian Best Practice Recommendations for Stroke Care. *CMAJ* 2008;178:1418-25.

DOI:10.1503/cmaj.080883

In the print version of a recent scientific article,[1] the sixth sentence in the research section of the abstract should read as follows: Patients were less likely to receive thromboprophylaxis after discharge if they had a longer hospital stay (15–30 days v. 1–7 days, OR 0.69, 95% CI 0.59–0.81). The online version is correct.

REFERENCE

1. Rahme E, Dasgupta K, Burman M, et al. Postdischarge thromboprophylaxis and mortality risk after hip- or knee-replacement surgery. *CMAJ* 2008; 178:1545-54.

DOI:10.1503/cmaj.080884

The name of one of the artists mentioned in a Left Atrium article in the May 20, 2008 issue was misspelled.[1] The correct spelling is Kelly Haydon.

CMAJ apologizes for any inconvenience this error may have caused.

REFERENCE

1. Fraser JL. The private and public nature of disease: Art as a transformative medium *CMAJ* 2008; 178:1467-9.

DOI:10.1503/cmaj.080885

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