Patient advocacy: health, money or both?

Dr. Bouzayen, in her recent editorial calling for public funding of in vitro fertilization (IVF),[1] makes a convincing argument that the current high cost of IVF acts as an incentive for women to request multiple embryo transfers to increase their chance of pregnancy, despite the risk of multiple gestation and its associated complications. But why are their physicians performing these potentially hazardous procedures? It would appear these doctors are acting in a manner that is at least as "short-sighted" as those who do not support funding IVF. This article may have inadvertently highlighted a deeper concern than the funding: Are doctors capable of advocating for a patient's health in the setting of competing patient-related factors? At a minimum, Dr. Bouzayen seems to have shown that we need serious improvement in this area.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/181/5/243#210888

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Competing interests of authors

I note that you have changed the threshold for determining whether the author has competing financial interests.[1] I would agree that this has been a fairly arbitrary level. Having said that, I do not know what your level has been in the past. What I would like to suggest is that you simply ask the authors to declare how much money in total they have received from all particular companies over the last five year period. If this material is presented to the readers, the readers would be in the position to make their own decision as to whether there was a conflict of interest. If someone has received $3 000 from a company, to my way of thinking it is much different than if they received several million dollars over five years. In the latter case, I would be prepared to believe that the physician may be seriously influenced by that level of income. It is my view that it would be a regressive step to abandon thresholds and I would urge you to go for total transparency, which would allow readers to make up their own minds on these matters.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/181/1-2/11#215069

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Primary care and type 2 diabetes mellitus

Re: "Controlling the complications of diabetes: It's about the sugar."[1] The controversy regarding glycemic control is further than ever from resolution. Type 2 diabetes mellitus (T2DM) is a common and growing primary care disease that attracts strong attention from the pharmaceutical industry. While management of T2DM, including diagnosis, treatment, monitoring, lifestyle and long-term patient–doctor relationship, is a primary care field, official guidelines originate from specialists and diabetologists without benefit of a strong primary care perspective. We in the field have repeatedly seen study results interpreted to support more interventions. The research use of relative risk, surrogate and composite endpoints does little to engender faith at the coal face of medicine. The hallmark of good primary care of a T2DM patient comes with understanding the care of the whole patient. Many of our patients are poor, uneducated, obese and suffer from multiple comorbidities. We must accept them as and where they are, moving forward at their pace. This means we need to keep it simple. Metformin and NPH (neutral protamine Hagedorn) insulin adjusted on 3 monthly A1c measurements is doable for most patients. On the other hand, frequent home glucose monitoring, highly advertised by a variety of entertainers at the behest of for-profit companies, is not supported by evidence. Most patients may be better served by discussing a different set of numbers: how many cigarettes they still smoke, the number of minutes of walking or exercise they achieve, how affordable their medications are. As things stand today, with the advertising being married to the clinical practice guidelines, those patients with T2DM who do not frequently measure their blood glucose are made to feel irresponsible at best, despite any evidence to support this. In the long term, this will work against the best interests of many patients.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/181/6-7/357#206053

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Euthanasia debate reignited

It is notable that after all the years of discussions that followed the Sue Rodriguez case, we are still insinuating that "pain so intense" (which painkillers do not alleviate) leads near-death

patients to ask that their life be ended.[1] Thanks to palliative care (and others), pain management has made so much progress in the past 40 years that most studies have shown that pain is NOT the primary reason to request euthanasia. Often, pain ranks 4th, 5th or lower.[2]

The most common motives are existential, a much less relievable type of suffering: profound deterioration, progressive loss of autonomy, unacceptable dependency, all leading to meaninglessness, even in spite of excellent palliative care. In a recent Canadian study, 6% of 379 palliative care cancer patients wanted euthanasia "now."[3] Modern dying, for a few, has become unacceptable. That explains the 80% support of Canadians, and that of 75% of Quebec's specialists recently reported. Yes, when appropriate and so wished by a near-death patient, euthanasia should be the "ultimate palliation."

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For the full letter, go to: www.cmaj.ca/cgi/eletters/181/8/463#220766

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Pandemic flu buddy system

As part of pandemic (H1N1) influenza planning, clinical departments across Canada are creating physician coverage plans. Our hospital department of psychiatry created a buddy system to meet this challenge. We paired physicians with a buddy, leveraging physician goodwill and personal sense of loyalty to each other. Buddy pairs were created taking into account clinical capacity and skill sets. Physicians covering in-patients were paired with those who primarily cover outpatients so as to not overwhelm any one in-patient physician and thus slow in-patient flow. Physicians who provide consultation to intensive care units (ICUs) and other high acuity work were paired with a buddy who generally provides lower acuity duties.

If ill, step 1, a physician can call their buddy. It is then the buddy's duty to cover, and triage their own duties as needed, or to do the phone calling to arrange for others to cover. Clinical triage priority principles were set to help guide workload triage decisions prioritizing the ICU and emergency department, then in-patient and general consultations, then day programs, then routine outpatient work.

In step 2, each buddy pair has another assigned buddy pair, with adequate clinical skills capable of covering each other, to go to next. Step 3 goes to the wider active staff then consulting staff lists. Physicians must start alphabetically with the name following theirs for a fair distribution of coverage requests. The algorithm is colour coded at each decision step. The plan has been well accepted by the department's physician group. We hope that sharing our experience is of help to others needing to meet this challenge.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/181/6-7/E102#223501

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Who is conflicted about handwashing?

In the news story "Conflict emerges over value of handwashing,"[1] a 2007 report, Influenza Transmission and the Role of Personal Protective Respiratory Equipment: An Assessment of the Evidence, is referenced as reason to cast doubt on the benefits of handwashing as a method for preventing the transmission of influenza and for supporting the use of N95 respirators in protecting the public. The report states that no evidence has been found that hand hygiene or other interventions prevent the transmission of influenza.

This ignores the substantive body of evidence that does support a role for hand hygiene in decreasing the likelihood of acquiring a respiratory tract infection (RTI), including severe RTI by more than 50% (OR 0.45).[2] The value of hand hygiene in preventing RTI was clearly stated in a 2007 Cochrane Review.[3] The 2007 report does not appear to make any recommendation on whether an N95 respirator should be worn in preference to a surgical mask to prevent influenza, nor does it cite any literature to support the use of either device in preventing influenza. The Cochrane Review found limited evidence of the effectiveness of N95 respirators over surgical masks.

A recently published randomized Canadian study demonstrated non-inferiority of surgical masks compared to N95 respirators in protecting health care workers from seasonal influenza.[4] Given the superior filtration capacity of N95 respirators compared with surgical masks, one explanation for this finding is that contact transmission prevented by hand hygiene and respiratory droplets may be the predominant means of transmission of influenza rather than small particle aerosols.

We acknowledge that new information will emerge as this pandemic unfolds. We also acknowledge the need to debate issues. But to pass off simple measures, for which there is an evidence base, and suggest others for which there is no evidence at all does health care workers and the public a disservice.

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