Letters

CMAJ publishes as many letters as possible. However, since space is limited, choices have to be made, on the basis of content and style; we routinely correspond only with authors of accepted letters. Letters that are clear, concise and convenient to edit (no longer than two double-spaced typescript pages, or 450 words) are more likely to be accepted. Those that are single-spaced, handwritten or longer than 450 words will usually not be published, without comment to the author or return of the letter; nevertheless, we reserve the right to abridge letters that are unduly long or repeat points made in other letters, especially in the same issue, as well as to edit for clarity.

Eligibility for CPR: Is every death a cardiac arrest?

Congratulations to Drs. Robert Buckman and John Senn for their thoughtful article on unnecessary or useless cardiopulmonary resuscitation (CPR) (*Can Med Assoc J* 1989; 140: 1068–1069).

Our CPR guidelines, which were written about 5 years ago, contain this footnote:

> Patients in whom cardiac or pulmonary arrest may occur as the end result of an inevitable and irreversible dying process, where death is expected within a few days, may be excluded from the request for verbal consent. Likewise, in certain clinical circumstances where the CPR procedure itself is considered contraindicated because it would induce further untoward medical complications and suffering. The physician should record the reason(s) for not asking the patient in the chart when activating such a DNR order.

This statement permits the avoidance of futile therapy.

Michael Kaye, MDiv, MB, FRCPC
Chairman
Ethics Committee
Montreal General Hospital
Montreal, PQ

Should terminally ill patients have to decide whether they should be resuscitated?

Often the ethical question raised in deciding whether to attempt resuscitation is one of sanctity of life versus quality of life. However, in the situation of the patient terminally ill with cancer is the offer of ineffective treatment really respecting the sanctity of a patient's life? Since CPR is of no proven benefit in such a case[1] the question raised by Drs. Buckman and Senn would appear to be When can a doctor make an independent decision about CPR without consulting the patient? Patients are seldom consulted about other forms of treatment that are deemed of no benefit, yet the decision to attempt resuscitation has entered an area now considered outside a physician's realm of decision-making.

Perhaps, in an attempt to become less paternalistic, doctors have opted to play a part in a melodrama in which a patient is offered an option that is truly not viable. Since support and freedom from anxiety are so vital in the care of the patient terminally ill with cancer this approach may be extremely unsettling. The patient's trust may be shattered if the physician offers treatment that he or she does not believe to be in the patient's best interest.

When CPR is deemed not clinically indicated and is therefore not offered, the question may be raised Has some possible benefit to the patient been overlooked? This is not an unusual scenario in medicine. However, the onus of exploring the benefit of a treatment modality should be the physician's rather than the patient's.

I believe it is our responsibility as physicians to offer only treatment that we consider to be of benefit. If a treatment cannot fulfil criteria needed to prove benefit, then it should not, in my mind, be considered an option.

Ron MacCormick, MD, FRCPC
Medical oncologist
Cancer Treatment and Research
Foundation of Nova Scotia
Halifax, NS

Reference

1. Bedell SE, Pelle D, Maher PL et al: Do-not-resuscitate orders for critically ill patients in the hospital: How are they used and what is their impact? *JAMA* 1986; 256: 233–237

Determinants of practice patterns

As a noncertified family physician who took a 1-year internship, I am happy that, once again, researchers could find no difference in practice patterns between physicians certified by the College of Family Physicians of Canada (CFPC) and those not certified (*Can Med Assoc J* 1989; 140: 913–918).

The findings of Dr. Samuel B. Sheps and his colleagues presented in the article "Practice patterns of family physicians

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