questions and concerns. Quinlan's first case was an elderly man who had a postoperative cardiac arrest and was subsequently unconscious in the intensive care unit (ICU) for 3 weeks. We are then told that the patient was transferred to the "palliative care ward, where a ventilator, respirator and total parenteral nutrition and hydration were maintained for another 3 weeks." Quinlan asks whether the "plug should have been pulled" after the first 3 weeks, since the patient was "obviously a vegetable." We are then told, without further explanation, that the patient is now perfectly well and 85 years old.

Cook's response misses several key points. First, it is difficult to imagine anyone calling a unit with mechanical ventilation a "palliative care ward." By definition, "palliative care implies the withdrawal of active curative treatment of the patient's condition following recognition that the patient has a fatal or terminal disease which cannot be cured."[1]

Second, the patient was, in retrospect, not a "vegetable" if he could subsequently make a full recovery. Good ethics follow from good medicine. An appropriate and sequential neurologic evaluation of the patient would have provided some clues about the eventual outcome for this patient.

In the second case, in which a man 42 years of age stated that he did not want to be resuscitated, the question is strictly one of the patient's competence. A competent patient has the right to refuse any treatment. If indeed the patient is found to be incompetent because of clinical depression, then he should be assessed and treated for his psychiatric condition, and his family should be involved in his care. "The mere fact that the patient/family/proxy selects a management option with which the physician disagrees does not make them incompetent."[2]

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References

1. Doyle D, Hanks GWC, MacDonald N. *Oxford Textbook of Palliative Medicine*. Oxford, England: Oxford University Press, 1993:497.
2. Koch KA. The language of death: euthanatos et mors. *Crit Care Clin* 1996;12(1):1.

[Dr. Quinlan responds:]

My original letter was written not as a clinical description of the management of either of the patients but as an example of the ethical dilemmas that confront us, often suddenly and at an inconvenient time (0230 hours) when we have no consultative assistance.

Granted, I omitted the clinical details of the unexpected survival of my patient in the first case. Believe me, the clinical procedures were intensive and involved many visits by a team of at least five physicians and surgeons.

Dr. Liben criticizes our transferring the patient to palliative care. The transfer was, to a large extent, an administrative decision based on the limited number of ICU beds and the hospital's accounting manoeuvres. The care the patient received was not the equivalent of that available in a full ICU but was still acceptable to the team of physicians, after some discussion with the family. In his second paragraph, Liben defines palliative care. The definition matches almost exactly what was done — care was provided for a terminal illness that could not be cured. The diagnosis of "terminal" was obviously mistaken. A "retrospectoscope" usually gives a much clearer view of the options.

The second case more or less took care of itself. The "retrospectoscope" has not helped solve this problem. The US Congress has just passed a law that would solve the legal problem by declaring that assisted suicide, under certain, unspecified circumstances, would not be a crime — a definite step onto a slippery slope. The ethics of the situation still pose a problem.

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"I THINK WE HAVE A PROBLEM IN VICTORIA": MDs RESPOND QUICKLY TO TOXOPLASMOSIS OUTBREAK IN BC [CORRECTION]

Because of a typographical error, this article by Anne Mullens (*Can Med Assoc J* 1996;154:1721-4) inadvertently referred to Raj Gill, supervisor of the nonviral serology laboratory at the BC Centre for Disease Control, as a male. We apologize to her for this error. — Ed.