

point in our lives; would anyone reading this not wish they could access their own chart, should the need arise?

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Competing interests: None declared.

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The language of living wills

In a recent article in *The Left Atrium*, Mark Belletrutti and Ingrid DeKock present and highly recommend a living will from “Edward,” one of their patients.¹ They write that “unlike many of today’s legally prepared documents, Edward’s document” gave real “insight into Edward’s views on life, death, infirmity and the burden of illness on family.” It “portrayed his deep personal conviction on end-of-life issues.”

In fact, Edward’s living will was professionally prepared. It was first published by distinguished bioethicists in *JAMA* nearly 25 years ago.² Since then it has been widely reprinted as a “form” living will.³⁻⁵

Granted, just because Edward used a “form” living will does not mean that its language did not reflect his preferences for end-of-life treatment. However, the language of this living will does not clearly indicate what Edward’s or any patient’s preferences actually are. What physical disabilities trigger the refusal of treatment? What measures are considered heroic? It is unreasonable to expect Edward to have

thought through all of the possibilities much less to have lucidly articulated preferences for every possible scenario. Consequently, perhaps it is time to abandon the living will and focus instead on the appointment of substitute decision-makers.⁶

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Competing interests: None declared.

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[The authors respond:]

Thaddeus Pope rightly points out that our patient’s living will¹ was a standard one that has appeared in several publications, including this journal.² Although his living will was professionally prepared using a standard template, our patient had to choose this document and its language over another living will that may not have adequately reflected his life situation and views at the time.

Pope also raises a more important issue, which is the need to focus on the appointment of substitute decision-makers to properly convey the wishes of a patient when he or she is unable to articulate his or her own wishes. The increase in the use of living wills is certainly beneficial, but an informed substitute decision-maker must assume the responsibility for taking the broad language of the living will and applying it to the current situation of the patient.

As pointed out by Pope, the language of the living will we presented in our *Left Atrium* article does not clearly indicate the patient’s preferences because it is impossible to prepare for all clinical situations. This living will

was an important first step in ensuring that proper discussions took place with our patient’s immediate family regarding the appropriate level of intervention at the end of his life. Ideally, this is the role the living will should play: it should be the starting point for productive discussions with the patient’s family and should afford the patient a voice when he or she is not able to speak for himself or herself.

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Competing interests: None declared.

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2. Houston CS. Living wills: a solution to the prolonged act of dying? *CMAJ* 1988;139:241-3.

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Corrections

A News article in the Feb. 12 issue about shortages of medical specialists contained an error. The Canadian Association of Emergency Physicians did participate in *CMAJ*’s canvass of specialty associations by providing a report on the issue.¹

REFERENCE

1. Howell, E. Physician, count thyself. *CMAJ* 2008; 178:381-2.

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We clarify that the death from rabies in Canada reported in the Feb. 26 issue¹ is the same case as that reported in the Feb. 29, 2008, issue of *Morbidity and Mortality Weekly Report*.²

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1. McDermid RC, Saxinger L, Lee B, et al. Human rabies encephalitis following bat exposure: failure of therapeutic coma. *CMAJ* 2008;178:557-61.
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