it falls outside the standard of care for cardiac arrest.[2] The patient in a PVS illustrates well the problem of medical futility. For these patients, the issue is not whether CPR is effective but rather whether the life is worth preserving. In my editorial, I argue that the joint statement[3] errs in allowing a physician to override the religious or cultural beliefs of the patient and her family and to unilaterally withhold CPR from a patient in a PVS. Through my own work as a clinical bioethicist, I am aware of physicians and hospitals that have interpreted the joint statement as allowing such unilateral action. If, as the CMA Committee on Ethics claims, my criticism is based on a "serious misinterpretation," then they must agree that these physicians and hospitals are acting immorally. I am sorry they did not take the opportunity to state this more clearly.

When Dr. Turnbull wonders who will bear the cost of providing CPR to patients in a PVS, he confuses 2 logically distinct issues: futile treatments, by definition, ought not be provided even if there is a surplus of resources.[4] In addition, resource allocation calls for an entirely different process than determination of futility, including an examination of cost-effectiveness data — he provides none — and community consultation. In the absence of such a process, a physician risks legal sanction if she denies available treatment to a patient on grounds of cost containment.[5]

Dr. Jespersen does not think the provision of CPR to a patient in a PVS is consistent with the primary goal of medicine, which is to provide benefit for the patient. Since a patient in a PVS is "irretrievably incapable of experience," she cannot experience benefit from CPR and, hence, it is "bad medicine" to provide it. But even if one accepts the premises of his argument — and I do not — the argument applies equally to all treatment, not just CPR. Thus, it would be just as unethical for a physician to provide a patient in a PVS with fluids by intravenous line or food through a feeding tube as it would be to provide CPR. If this is, as I suspect, inconsistent with the moral intuitions of physicians, then a new moral justification for withholding CPR from all patients in a PVS must be sought.

I am grateful for the support offered in the letters of Drs. Walker and Gutowski. Respect for the religious and cultural beliefs of our patients and their families is an indispensable part of good medicine.

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References

1. Bedell SE, Delbanco TL, Cook EF, Epstein FH. Survival after cardiopulmonary resuscitation in the hospital. *N Engl J Med* 1983;309:569-76.
2. Weijer C, Elliott C. Pulling the plug on futility. *BMJ* 1995;310:683-4.
3. Joint statement on resuscitative interventions (update 1995). *CMAJ* 1995;153(11): 1652A-C.
4. Jecker NS. Futility and rationing. *Am J Med* 1992;92:189-96.
5. *Law Estate* v *Simice* (1994), 21 CCLT (2d) 228 (BCSC), aff'd, [1996] 4 WWR 672 (BCCA).

Thucydides' syndrome

The disease described by Dr. John Hoey in his article "Anthrax" (*CMAJ* 1998;158[5]:633) is indeed an old disease, appearing in chapter 9 of Exodus as the fifth and sixth plagues of Egypt and in Virgil's third Georgic as the murrain of Noricum.[1]

Epidemic inhalational anthrax on a scale unknown before or since may well have been the cause of one of medical history's greatest conundrums, the plague of Athens, also known as Thucydides' syndrome, a serious infectious disease that ravaged the Athenians during the Peloponnesian war between 430 and 427 BC.[2] Surprisingly, even though Thucydides left an excellent description of the disease's epidemiology and clinical features,[3] there has never been

agreement on the precise nature of the illness that weakened a nation so much that the course of geopolitical history was irrevocably changed.

The 1979 epidemic of inhalational anthrax in Sverdlovsk offers excellent confirmation that such events are indeed possible, albeit on a much smaller scale, and provides strong, if somewhat circumstantial, support for the thesis that Thucydides' syndrome was in fact inhalational anthrax.

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References

1. Christie AB. Clinical aspects of anthrax. *Postgrad Med J* 1973;49:565-70.
2. McSherry JA, Kilpatrick R. The plague of Athens. *J R Soc Med* 1982;85:713.
3. Thucydides. *History of the Peloponesian war*. Warner R, translator. London: Penguin Books; 1954.

Correction

In the article "Evidence-based guidelines for universal counselling and offering of HIV testing in pregnancy in Canada" (*CMAJ* 1998;158[11]:1449-57), by Drs. Lindy Samson and Susan King, Fig. 1 on page 1455 contained an error in the branch for women who decline testing. The information about infant outcome applies to untested women who are positive for HIV, as shown here.

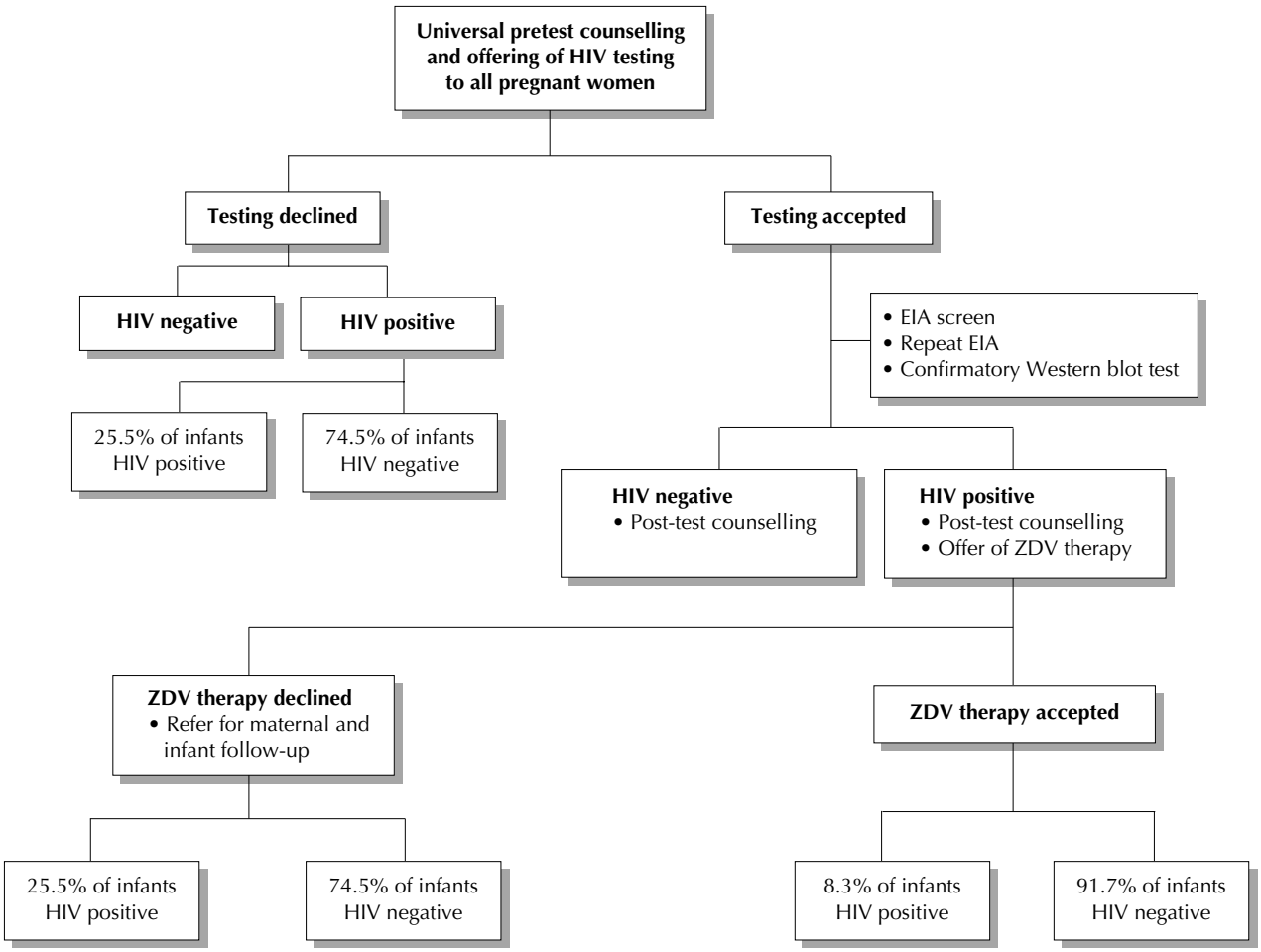

Fig. 1: Recommended strategy for universal HIV screening among pregnant women in Canada. Outcomes have been estimated from results of the Pediatric AIDS Clinical Trials Group protocol 076 trial.[3] EIA = enzyme-linked immunosorbent assay, ZDV = zidovudine.