method, with its emphasis on disinterested investigation, careful analysis of data, conservative scepticism and consensual agreement, is the best method human beings have for approaching the truth.[2]

Hoey is incredibly naïve to think that there must be merit in alternative therapies because those with "a higher level of education" use them. Education (it is sad to admit) does not guarantee the ability to think critically and to use an informed scepticism in considering claims for the effectiveness of treatments.

It is misleading to refer to scientific medicine as "the establishment." This term connotes some rigid ideological position whereas the scientific method has revealed, not just in medicine, a continually changing reality through revisions and self-correction.

If patients are "taking control of the agenda" regarding their treatment, let them do so. But let us not dignify treatment that is completely unsupported by scientific evidence with a medical endorsement. The best physicians can do is to inform patients of the lack of valid evidence supporting claims for alternative treatments (with a few exceptions) and to try to instill in patients an enlightened scepticism. I recommend to many patients *The Wellness Letter* published by the University of California at Berkeley. Contrast the sceptical (not negative) attitude toward alternative treatments in this publication intended for the lay public with the *CMAJ* articles criticized by Ian Tannock and David Warr.[3]

This editorial would have been bad enough coming from any physician. Coming from the Editor of *CMAJ* it makes me sad and embarrassed to be a member of the Canadian Medical Association.

Paul C.S. Hoaken
Psychiatrist
Bath, Ont.

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2. Strahler AN. *Understanding science*. Buffalo (NY): Prometheus Books; 1992.
3. Tannock IF, Warr DG. Unconventional therapies for cancer: A refuge from the rules of evidence? *CMAJ* 1998;159(7):801-2.

[Editor's note:]

Owing to an editorial oversight, this letter was not published in 1999 as scheduled.

Overnight dialysis

In June 1968, a colleague and I reported the case of a 14-year-old malnourished girl with end-stage renal disease who was dialysed daily, except Sunday, for 8–14 hours overnight.[1] She had an excellent response, went home on this regime and eventually received a transplant. In October of the same year, we described our experience with 22 patients on home hemodialysis, 20 of whom were dialyzed 10 hours overnight 3 times weekly with the patient asleep for most of the procedure.[2] This regime was initiated by groups at the Royal Free Hospital in England[3] and in Seattle.[4]

My question to Andreas Pierratos, the author of "Nocturnal hemodialysis: dialysis for the new millennium,"[5] is this. To which millennium was he referring?

Michael Kaye
Nephrologist
Hudson, Que.

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1. Kaye M, Comty C. Nutritional repletion during dialysis. *Am J Clin Nutr* 1968;21:583-9.
2. Kaye M, McDade D, Dufresne L, Comty C. Hemodialysis at home. *CMAJ* 1968;99(16):779-85.
3. Baillod RA, et al. *Proc Eur Dial Transplant Assoc* 1965;2:99.
4. Curtis FK, Cole JJ, Tyler LL, Scribner BH. Hemodialysis in the home. *Trans Am Soc Artif Intern Organs* 1965;11:7-10.
5. Pierratos A. Nocturnal hemodialysis: dialysis for the new millennium. *CMAJ* 1999;161(9):1137.

[The author responds:]

I agree that the Tassin regimen of long dialysis 3 times a week is well known and inspirational. I believe that the systematic study and programmed application of the long and frequent dialysis regimen (nocturnal hemodialysis) will make it the preferred dialysis modality for a large number of patients. By the end of this year, 60 to 80 patients will be receiving nocturnal hemodialysis in Ontario, and a faster growth is anticipated in the future. This indeed makes it the most exciting dialysis modality in the new millennium.

Andreas Pierratos
Nephrologist
Humber River Regional Hospital
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The journey through the ICU

As a neurosurgeon who deals with critically ill patients every day, I read a recent article by Deborah Cook and colleagues with interest.[1] Upon reflecting, I felt that understanding of the reasons why advanced life support is withheld, provided, continued or withdrawn in the ICU could be enhanced by using an alternative metaphor: that of the ICU stay and its attendant use of technology as a journey.

At times the journey is complete by the time the patient arrives in the ICU. At other times, however, the journey through the ICU becomes a trip through uncharted waters, and in these cases the ship has no power against the ravages of nature.

In this context, medical technology may be viewed as one means of taking the journey. The withdrawal of support may be viewed as halting one means of transportation, while its continuation may be considered a decision to carry the traveller — the patient — forward. When technology is withheld, it may be considered a means of travel that the traveller cannot or chooses not to use.

Other modes of transportation are possible for journeys. This might be the reason why some patients have positive outcomes in the course of their illness that cannot be explained by contemporary western medicine.

On the journey through the ICU, there are many travellers. They are all affected by the trip, whether they consciously realize it or not. In a journey,

the travellers may make decisions on the means of passage they will take on the basis of their best intentions to reach a destination.

Michael Cusimano
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Reference

1. Cook DJ, Giacomini M, Johnson N, Willms D, for the Canadian Critical Care Trials Group. Life support in the intensive care unit: a qualitative investigation of technological purposes. *CMAJ* 1999;161(9):1109-13.

A fine old country doctor

I read Edward Ralph's editorial on Powassan encephalitis with interest.[1] Powassan is a small community 35 km south of North Bay, Ont. A family doctor, R.H. Dillane, practised there for more than 50 years, and he diagnosed the disease that became known as the Powassan virus.

He referred the patient to Toronto and told the specialists at the Hospital for Sick Children how the child had contracted the disease. The specialists and researchers agreed with his diagnosis and then named the disease the Powassan virus.

RH, as he was known, never sent bills. He practised 7 days a week. He made house calls. In winter, he would travel with team and cutter. He never made much money. One year, when many doctors were away at the war, he delivered 233 babies in a house in town with the help of a nurse. He was highly regarded as an excellent diagnostician. It was said that, with little more than a history and physical examination, "he could just smell the problem."

A local newspaper once published a photo of a doctor who was retiring from practice and commented that he had delivered 1000 babies. RH had a good chuckle over that one. "Heck," he said, "I had a 1000 deliveries for which I never got paid."

How nice it would have been if this disease had been called the Dillane virus in honour of the fine old country doctor who discovered it.

William J. Copeman
Family physician (retired)
Beaverton, Ont.

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1. Ralph ED. Powassan encephalitis. *CMAJ* 1999;161(11):1416-7.

CMAJ index
L'index du *JAMC*

The index for volume 161 (July–December 1999) of *CMAJ* was mailed with this issue to paid subscribers and to CMA members who requested it from the CMA Member Service Centre. Others may order single copies for $15 (within Canada; add 7% GST/15% HST as applicable) or US$15 (outside Canada).

Les abonnés en règle et les membres qui en ont fait la demande auprès du Centre des services aux membres recevront l'index du volume 161 (juillet à décembre 1999) du *JAMC* en même temps que le présent numéro. Pour les personnes intéressées à commander l'index, il en coûte 15 $ (au Canada; ajouter la TPS de 7 % ou la TVH de 15 %, selon le cas) ou 15 $US (à l'extérieur du Canada).

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Correction

Owing to a production error, the reference footnotes are missing from the text of Christopher Doig's recent commentary.[1] The corrected text is available on *eCMAJ* (http://www.cma.ca/cmaj/vol-162/issue-3/issue-3.htm).

Reference

1. Doig C. Education of medical students and house staff to prevent hazardous occupational exposure. *CMAJ* 2000;162(3):344-5.