KPD, a distinctive novel pathogenic process of defective energy production and ketosis may be at play.

Given space limitations, we were unable to describe specific populations with monogenic diabetes, but we hope that our focused discussion of HNF1A monogenic diabetes will stimulate consideration of this type of diabetes.

We agree that regional variation and location of practice are highly relevant. For example, in our hospital, which serves a large, underserved, heterogeneous urban population, ketosis-prone diabetes is the most common reason for admission to the intensive care unit with ketoacidosis. Type 1a diabetes is less common in our particular setting.

Naturally, diet and lifestyle modification form the cornerstone of all diabetes therapeutics. We acknowledge that controversies surrounding diabetes classification continue to exist, but recognition of a possible atypical diabetes phenotype is an important part of primary diabetes care.

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## Beyond resuscitate and do-not-resuscitate

We applaud Hebert and Selby[1] for examining the difficulties of responding to iatrogenic or potentially readily reversible critical incidents in patients with a do-not-resuscitate order. Several Canadian health authorities have already replaced do-not-resuscitate orders with more nuanced medical order frameworks (Goals of Care Designations[2] in Alberta and Medical Orders for Scope of Treatment[3] at Fraser Health, BC) to better reflect patient values and medical care appropriate to their context.

These medical orders are determined through a process of communication between a patient, surrogate decision-makers and health care providers. The orders convey information about the types of interventions to be used or withheld, the location of care and most importantly the general intention of care. System-wide policies and procedures ensure that the order and documented discussions travel with the patient. These frameworks are implemented with advance care planning initiatives[4] normalizing early reflection and communication, which can assist in health care decision-making.

Although not a panacea for ethical dilemmas, such frameworks greatly inform decision-making. They are an improvement over binary resuscitate or do-not-resuscitate orders and prior conversation details buried in health records.

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### The authors respond

We thank Simon and colleagues[1] for their response to our article.[2] We applaud the initiatives they describe. We think it important that they combine the Goals of Care Designations with the documentation of the discussions leading to the decisions made by each individual patient. We are encouraged by the uptake of these ideas in many jurisdictions and look forward to their adoption across Canada.

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## About bloody time

Coincidentally, I read Dr. Shuchman's article[1] regarding the risks of iron deficiency with frequent blood donation while I was laying in a chair in Toronto donating whole blood. I am a frequent blood donor myself, and over the last year I have watched with growing trepidation the ever-decreasing level of my hemoglobin at the point of donation. A course of iron supplementation seems to have done the trick, and I am actually feeling quite a bit more energetic as well. I am happy to hear that Canadian Blood Services will be piloting routine ferritin testing, although there is some recent evidence suggesting that reducing body iron stores may have beneficial effects on blood pressure, blood glucose and other metabolic parameters.[2] In the absence of frank anemia, one wonders if there is an optimal ferritin level which balances the potential for chronic disease prevention and the risk of fatigue. Hopefully, future studies will guide us in this regard.

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