



using evidence-based rationing. MacLeod and Bienenstock call on conventional wisdom when they state that there are "services that everyone agrees should be provided, such as home care...." I have recently reviewed the literature of controlled trials involving home care and find it difficult to convince myself that there are significant outcome or economic benefits from this type of care. My view is supported by a recent study by the Institute for Clinical Evaluative Sciences (ICES) that was reported in the *Medical Post*.<sup>1</sup> Dr. Peter Coyte of ICES has pointed out that there are no studies showing that home care is a truly cost-effective alternative to hospital care. The ICES study itself stated that "In the absence of evidence-based decision making, health system restructuring may result in more, not less, costly patterns of practice, and erode, not enhance, health outcomes." It is clear that although evidence-based rationing is not perfect, rationing of limited resources must happen, and there is no better mechanism known.

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#### Reference

1. Wysong P. With Ontario hospitals closing, home care needs \$91M: ICES. *Med Post* 1998;34(1):2.

#### [One of the authors responds:]

The logic of Dr. Byrne's position is elusive. It may be true, as Dr. Coyte is reported to have said, that there is only weak evidence supporting home care as a cost-effective delivery system, but there are many types of home care that make abundant common sense beyond the probing reach of either health economists or supporters of evidence-based rationing. Or is Byrne suggesting that potential solutions with weak evidence warrant only modest funding? This would represent a new but unappealing ap-

proach. In any case, the absence of evidence should never be confused with evidence of absence. It would be hard to justify a randomized controlled trial to show the obvious benefit of home care that respects personal choice and improves quality of life for many. Therefore, Byrne's apparent willingness to accept rationing on the basis of nonexistent or imperfect scientific studies remains surprising. No wonder some of us are alarmed by the misappropriation of evidence-based medicine by governments trusted with health care decisions.

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## Connaître les codes d'éthique et les appliquer

Dans l'éditorial «Sound privacy for patients» (*JAMC* 1998;158 [5]:613-4), le Dr Kenneth M. Flegel et Mary Lant décrivent diverses situations où il y a rupture de la confidentialité requise du médecin ou de son entourage : consultations entendues par d'autres malades, échanges indiscrets du médecin ou de son personnel. Ils émettent, entre autres, le souhait que les médecins spécifient dans leurs codes d'éthique les éléments de base de la confidentialité.

Comme l'un des auteurs le sait sûrement, car il exerce à l'hôpital Royal Victoria de Montréal, le code de déontologie qui régit sa pratique au Québec prévoit<sup>1</sup> :

- 3.01 Le médecin doit garder secret ce qui est venu à sa connaissance dans l'exercice de sa profession; il doit notamment s'abstenir de tenir des conversations indiscrètes au sujet de ses patients ou des services qui leur sont rendus ou de révéler qu'une personne a fait appel à ses

services, à moins que la nature du cas ne l'exige.

- 3.02 Le médecin doit prendre les moyens raisonnables à l'égard de ses employés et du personnel qui l'entourent pour que soit préservé le secret professionnel.

Par ailleurs, dans un autre règlement adopté dans le cadre de la même Loi médicale du Québec, il est stipulé<sup>2</sup> :

- 2.01 Le médecin doit aménager son cabinet de consultation de façon à ce que les conversations entre lui, son personnel et le malade ne puissent être perçues par d'autres.

L'agencement des divers locaux du cabinet doit assurer l'intimité de la clientèle.

Voilà qui répond à quelques préoccupations des auteurs, mais à quoi sert-il d'avoir des règlements déontologiques si on ignore leur existence? Il est de la responsabilité du professionnel de respecter les divers règlements et lois qui régissent sa pratique. L'existence seulement de règlements ne suffit donc pas — il faut aussi les connaître, et les assimiler dans la pratique de tous les jours.

**Benoit L. Poulin, MD**  
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#### Références

1. *Code de déontologie des médecins*, RRQ 1981, c M-9, r 4.
2. *Règlement sur la tenue du cabinet de consultation d'un médecin*, RRQ 1981, c M-9, r 20.

#### [Un des auteurs répond :]

Nous remercions le Dr Poulin d'avoir attiré notre attention sur les passages du Code de déontologie du Québec qui traitent de la protection des conversations privées. Toutefois, en écrivant l'éditorial, nous songions à un contexte plus vaste que celui de la seule province dans laquelle chaque médecin pratique. Ma propre expérience de la pratique dans



cette province, comme l'illustre l'éditorial, porte à croire que le Québec aussi aura à déployer des efforts de haute lutte pour atteindre la norme qu'exige sa propre loi.

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## Alternatives to blood transfusion are risky too

I would like to make 3 points in reply to Dr. J. Mervyn Thomas's letter "Blood transfusions: listen to the patient" (*CMAJ* 1998;158[5]:585) and his plea for increased use of alternatives to allogeneic blood.

It is true that patients are more aware now than they were a decade ago of the risks associated with allogeneic transfusion. However, are patients making realistic risk estimates, and are they also aware of the risks of the alternatives? Just as blood products will never be without risk, it is also unlikely that effective alternatives will ever be without risk. For example, autologous predonation is associated with bacterial infection<sup>1</sup> and transfusion reactions because of laboratory error.<sup>2</sup> Indeed, the frequency of these side effects may be higher than with allogeneic blood, because patients who predonate often receive more transfusions than those who do not.<sup>3</sup> Concern remains about the risk of thrombosis associated with aprotinin<sup>4</sup> and erythropoietin,<sup>5</sup> and it must be remembered that relatively few patients have participated in trials of pharmacological agents. Because the frequency of severe side effects from allogeneic blood is now very low, studies of the alternatives must involve large numbers of patients to be sure that they are just as safe.

Unfortunately, the cost-effectiveness of many of the alternatives to allogeneic transfusion has not been well established. Indeed, most well-

designed studies have found the cost-effectiveness of preoperative autologous donation and erythropoietin unattractive according to conventional criteria.<sup>6,7</sup>

Finally, I believe the term "bloodless surgery" can be misleading. It implies to patients that major surgery can always be achieved without blood transfusion.

Rather than providing patients with false expectations, we should be encouraging frank discussion of the benefits and risks of both allogeneic transfusion and its alternatives.

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- sion reactions. *MMWR* 1997;46:553–5.
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### [The author responds:]

I applaud Dr. Laupacis's recommendation for additional studies of medical alternatives to transfusion. Comprehensive blood conservation

## CMA index

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