Physicians' role in care of loved ones

We read with great interest the article "Too close for comfort? A family physician questions whether medical professionals should be excluded from their loved ones' care" (*Can Med Assoc J* 1997;156:53-5), by Dr. Michael C. Klein, regarding his experiences with the hospital care of his wife after she suffered a debilitating stroke. Klein shares his views on whether a physician who is a family member should be excluded from a loved one's care. It is commonly held that it is improper for a physician to be involved in the care of a loved one because his or her judgement may be clouded and perspective lost.

However, in Klein's case he was the substitute decision-maker or he may have had power of attorney over his wife's care. In such a situation, decisions must include the opinion and informed consent of the family member, regardless of his or her profession. Therefore, deciding the extent to which family members need to be involved based on their occupation is discriminatory.

In our surgical practice we have always tried to include the opinion and comments of family members who are physicians, but only if the patient approves. We have found that this practice pleases the patient, puts the family at ease, helps build trust and rapport with the family and provides us with a contact who can then share information with other family members.

Klein describes a rather disturbing incident that occurred when "one nurse asked [him] to leave, saying that she couldn't do her work with [him] there." This would be considered completely unacceptable on a pediatrics ward, where children rely on the comforting hand of a parent or guardian. Why is this any different if an adult patient is involved? Again, if the patient's best interests were kept in mind, these confrontations would never happen.

We have never asked a family member to leave unless it was necessary for patient comfort. Indeed, several of our patients are physicians. If we were the least bit unsure about our skills as health care providers, how would we deal with these patients? If one of us has a problem with someone observing our technique, the problem lies with the worker and not the observer. The patient should not suffer because of it.

Carmine Simone, PhD
Division of Clinical Pharmacology
Hospital for Sick Children
Toronto, Ont.
Martin Seidenschmid, DDS, MD
Philadelphia, Pa.

The great divide

The Pulse column "MD fees much higher in US" (*Can Med Assoc J* 1997;156:960) illustrated the great discrepancies between physicians' fees in the US and Canada. The difference in fees reported in the article is 600% and even higher. I am sure that most Canadian physicians would feel handsomely rewarded if they made 100% — maybe even 50% — more, never mind 600%. Meanwhile, we are missing a golden opportunity. We should use this information to win the minds and hearts of Canadians by making them aware of their good fortune.

We do not need the expensive TV commercials politicians use — all we need is a weekly "one-liner" posted in the waiting room of every physician's office. Among other things, these posters could remind patients that their physicians "give Canadians the best bang for the buck."

In the past, many of us have been reluctant to "toot our own flute," but this is the wrong stance. We need not only a CMA MD–MP contact program but also a CMA department that maintains and nurtures the image of physicians.

I have cut out page 960 of the Mar. 15 *CMAJ* and inserted it in a photograph album that I keep in the office for patients. It contains items of medical, political and social interest, and page 960 will undoubtedly fly under the banner "More bang for the buck."

May I say it is a delight to receive *CMAJ* and to be able to keep it in focus to the end of an article. The new typeface is a great choice.

Gabriel J. Slowey, MD
Chesterville, Ont.
Received via e-mail

Cutting tobacco taxes, endangering youth

The article "The effect of tobacco tax cuts on cigarette smoking in Canada" (*Can Med Assoc J* 1997;156:187-91), by Dr. Vivian H. Hamilton and associates, is an interesting attempt to address the impact on smoking of the major cuts in federal and provincial cigarette taxes in 1994. However, I am concerned that methodologic weaknesses in the survey conducted by Statistics Canada could have led to an underestimation of the impact of the cuts.

Starting smoking occurs predominantly during the teenage years. One major concern about the tax cuts was that they would make cigarettes more available to teenagers, especially to those younger than 15, whose smoking habits are more price-sensitive.