Physicians: think twice before witnessing a will

Almost 30 years ago, 2 doctors practicing at a military hospital in Halifax acted as witnesses for the signing of a will. This probably seemed an appropriate thing to do at the time, since the patient was extremely ill and wanted to ensure that his last wishes would be carried out. In fact, the man made a full recovery and died only a few months ago.

Following his death, the lawyer representing his widow tried to locate the witnesses. It wasn't an easy job. With help from the Medical Society of Nova Scotia, he finally learned that one of the physicians is now practising in New Brunswick, while the other doctor's whereabouts remain a mystery. Faced with the task of contacting the New Brunswick doctor and arranging for him to visit a probate court to confirm that he served as a witness to the 1969 will is clearly frustrating to the lawyer involved. He wasn't even sure if this could be done in New Brunswick, or would require a trip to Nova Scotia. Regardless, the doctor involved would face considerable inconvenience.

The lawyer said physicians should be discouraged from witnessing wills: in most cases a lawyer should execute the document and assume responsibility for providing witnesses. There are several pitfalls inherent in witnessing patients' wills. These include the possibility of becoming involved in a court case should a will be contested. Doctors are often asked to provide a medical opinion on the mental status of a patient at the time a will is completed, but this is an ethical and legal obligation that cannot be avoided. However, physicians who are asked to witness a will should consider several points: the possibility they will relocate, the availability of more appropriate witnesses

Canadian engineer left to his own devices

When the National Research Council recruited John Hopps 48 years ago, he never dreamed he would become involved in creating one of the world's most groundbreaking medical devices. He also never thought he would eventually need the device himself.

In July, the 78-year-old retired electrical engineer checked into the University of Ottawa Heart Institute to be fitted with his second demand pacemaker because the battery in his first one, implanted 13 years ago, had finally lost its charge. "I had to persuade [doctors] this thing was reaching the end of its life and was causing random pulses that I didn't like," says Hopps. He should know.

While working on hypothermia studies in the University of Toronto's Department of Surgery in 1949, Hopps was recruited to develop a device that could produce an electrical impulse to stop ventricular fibrillation. Using his expertise in microwave and high-frequency heating, he helped develop an approach in which an electrode was placed on the heart through the open chest of a dog while another

John Hopps

electrode was placed on the body surface. "I didn't know anything about conduction blocks at the time," he confesses.

Nevertheless, with the backing of the National Research Council Hopps and the team refined their technique and delivered the world's first cardiac pacemaker in early 1950. The device included transvenous catheter electrodes, which are still used for implantable pacemakers today, but relied on vacuum tubes. Transistors would help decrease the size of the pacemaker about a decade later.

An officer of the Order of Canada since 1986 and author of a 1995 book, *Passing Pulses, the Pacemaker and Medical Engineering: A Canadian Story*, Hopps says he is "constantly amazed at how technology" has refined the device he helped create 47 years ago. Recognition that he is indeed a medical pioneer hit home when he talked with Dr. Wilbert Keon, director of the Heart Institute, before his latest procedure. "Willie said to me, 'This is going to make news,' " explains Hopps. "He was right." — © *Christopher Guly*

and the potential legal ramifications.

In Halifax, the Queen Elizabeth II Health Science Centre has instituted a policy that states hospital personnel are not permitted to witness documents generated outside the hospital that are not related to patient care, such as deeds and wills. The hospital's legal counsel, Nancy Milford, says it is inappropriate for hospital staff to become involved. The decision followed experiences in which such documents proved to be a problem for both hospitals and the physicians involved.

The hospital does acknowledge that there will be times when no other option is available, and it has appointed commissioners of oath for this purpose. The province's lawyers have been notified of the policy. For physicians, the best advice is that a wise doctor will think twice before agreeing to witness legal documents that are irrelevant to patient care. Such action may save them and their patients unneeded grief. — © *Dorothy Grant*, coordinator, patient–physician relations, Medical Society of Nova Scotia.

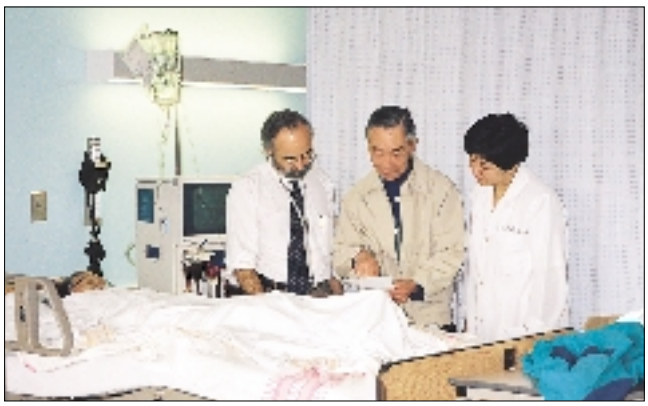
CMA adds voice to call for land-mine ban

The CMA has joined the chorus calling for a ban on the use of antipersonnel land mines. The often-undetectable mines, which the *Economist* recently described as "cheap little horrors," kill or maim about 25 000 people a year. They continue taking their toll long after wars end because they are seldom defused. In a unanimous vote cast during the August annual meeting, the CMA lauded Canadian attempts to achieve a signed treaty banning the mines by this December. That treaty proposal received its biggest boost while the CMA annual meeting was under way, when the US announced it would support the Canadian plan. Three months ago it had dismissed the "Ottawa process" as unrealistic, but support had grown in the US, particularly among war veterans.

A report released in July indicated that during the Korean war American troops were more likely to be killed by their own mines than communist ones. Although the Ottawa process is unlikely to achieve a total ban because countries such as India and China will refuse to sign it, 106 countries had announced their support by

Language barriers fall at Vancouver hospital

Canada's changing demographics are changing the way some hospitals deal with patients. For instance, St. Paul's Hospital in Vancouver's populous west end now trains staff and volunteers in language interpretation in order to serve the large number of new Canadians living downtown. Some 120 staff members who speak a total of 45 different languages have volunteered for the training. The program is run by Anneke Rees, the coordinator of volunteer resources, who says "we could always use more." Staff receive a 6-hour training session that emphasizes impartiality and accuracy. Control remains with the patient, explains Rees, because the interpreter is "not responsible for making things work out."



Dr. Ron Werb (left) and translator Alison Chan answer questions from a patient's relative

Cantonese translation is most in demand by far, followed by Gujarati, an Indian dialect, and Vietnamese. Translation for Polish and Russian patients is sometimes needed, for these new arrivals tend to concentrate in Vancouver's west end. Rees emphasizes that the program involves language interpreting and not cultural interpreting, in which interpreters may act as advocates for patients. The St. Paul's interpreters inform the health professionals involved if a cultural issue arises, but stay neutral.

The hemodialysis unit makes the greatest use of interpreters, both during predialysis education sessions and dialysis treatment. Dr. Ron Werb, the unit director, says about 50% of the patients speak Cantonese and he finds the service "absolutely invaluable in reducing patient anxiety." Bolstering interpretation skills within the unit is Alison Chan, a Cantonese-speaking clerk, who has taken the training and uses it frequently.

Rees says service delivery remains the program's greatest challenge. Although some procedures allow staff to reserve an interpreter, in most cases translation services are needed without notice. All parts of the hospital can call upon the volunteers around the clock, and a commercial service is available as a backup option. — © *Heather Kent*