## Detached doctors, distressed patients

I have been interested in reports of recent changes in the training programs for doctors, particularly in the area of improving communication skills. A recent experience indicated to me that it is not only communication about the patient's medical condition that needs to be assessed, but also communication on a personal level.

Three months after surgery and about 3 days after my final check-up I became obsessed with the surgeon who had performed the operation. The 5 or 6 weeks that followed were the most frightening of my life: this man completely occupied my mind. I initially thought that I was infatuated but then realized that there was not even a glimmer of eroticism in my mental encounters with the man. Fortunately, I was able to discuss this situation with others and came to consider my experience as post-traumatic stress syndrome, even though I had some doubts about that diagnosis.

As the obsession faded I was able to examine what had happened. In my mind I was continually trying to talk to the surgeon, not about medical matters but just simple conversation — I wanted to establish a personal relationship that had never existed. The surgeon had treated me with impersonal professionalism: he had explained the procedure, the risks and the after-effects. I wouldn't dream of questioning his technical expertise, but I have never before been in a situation in which I was treated as a "case" or an "object," not a person. I assume that my obsessive attempt to communicate with him on a personal level was some sort of rejection of the way I had been, or rather had not been, treated.

I realize that patients often attach themselves to doctors in a dependent way, but I have also spoken with a number of other patients with experiences similar to mine. And I have read the chapter "The patient examines the doctor" in Anatole Broyard's book *Intoxicated by My Illness*, where he too talks of wanting a relationship with his doctor. So I know that my feelings are not unique. It is not that we are attached to these doctors who treat our medical problems, but rather that we must come to grips in some way with the sense that we are not persons to them. This attitude, I suggest, is beneficial neither to patients' mental health nor to doctors themselves, for they may carry this same detachment into their personal lives.

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## Which Korotkoff sound?

The work presented in the "Report of the Canadian Hypertension Society Consensus Conference: 1. Definitions, evaluation and classification of hypertensive disorders in pregnancy" (*Can Med Assoc J* 1997; 157[6]:715-25) is commendable. The recommendations are evidence driven, clear and clinically relevant.

I believe, however, that the recommendation to use the fourth Korotkoff sound to mark the diastolic blood pressure and "for instituting clinical investigation and management" is unfounded. Phase IV of the Korotkoff sounds is not reproducible among clinicians, whereas phase V is.[1] Furthermore, current clinical trials of hypertension during pregnancy have adopted the the fifth Korotkoff sound in defining outcomes and guiding therapy,[2] which raises the issue of external validity if Canadians define hypertension during pregnancy according to different criteria.

The recommendation to measure both the fourth and fifth sounds is confusing for the average physician, nurse or midwife, especially if they are encouraged to act upon only the fourth sound.

We should agree to standardize blood pressure measurement — during pregnancy and otherwise — by having the rested patient sit upright, supporting her arm, applying the correct size cuff and relying on the first and fifth Korotkoff sounds to denote the systolic and diastolic pressures respectively.

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**References**

1. Shennan A, Gupta M, Halligan A, Taylor D, DeSwiet M. Lack of reproducibility in pregnancy of Korotkoff phase IV as measured by mercury sphygmomanometry. *Lancet* 1996;347:139-42.
2. Levine RJ, Hauth JC, Curet LB, Sibai BM, Catalano PM, Morris CD, et al. Trial of calcium to prevent preeclampsia. *N Engl J Med* 1997;337:69-76.

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

Dr. Ray has touched on one of the more controversial issues in our report: Which of the 2 Korotkoff sounds, phase IV or phase V, should be used to define diastole in pregnancy?

During our consensus deliberations, we looked for publications that correlated the Korotkoff sounds to a gold standard of arterial intravascular diastolic pressure measurements. Unfortunately, our search yielded conflicting results,[1–4] some data showing that the Korotkoff phase IV sound

was a more reliable reflection of the true intravascular diastolic pressure as determined by invasive techniques, and other data favouring the phase V sound.

There is little doubt that the Korotkoff phase IV sound is subject to greater interobserver and intraobserver variability than the phase V sound,[5] but the latter may occasionally be falsely low.[6] Although diastolic pressure measurements as determined by the phase IV sound may be 5 to 8 mm higher than those determined by the phase V sound,[5] the difference is reduced in hypertensive states of pregnancy.[7]

Faced with a lack of reliable data to support adopting either the phase IV or the phase V sound, the members of the consensus group felt that the phase IV sound, by virtue of its being slightly higher than the phase V sound, might offer a wider margin of safety in initiating surveillance for the possible complications of hypertensive disorders of pregnancy. Most societies and interest groups, as well as many leading authorities in the study of hypertension, have recommended using the phase IV sound to determine diastole in pregnancy.

Recommending that clinicians record both sounds is not an original idea. The American National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy[8] recommended that both sounds be recorded.

Canadian research in this area is urgently needed. Our recommendations will be revisited in the future, especially when more evidence becomes available.

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**References**

1. Wichman K, Ryden G, Wichman M. The influence of different positions and Korotkoff sounds on the blood pressure measurements in pregnancy. *Acta Obstet Gynecol Scand Suppl* 1984;118:25-8.
2. Villar J, Repke J, Markush L, Calvert W, Rhoads G. The measuring of blood pressure during pregnancy. *Am J Obstet Gynecol* 1989;161:1019-24.
3. Johenning AR, Barron WM. Indirect blood pressure measurements in pregnancy: Korotkoff phase 4 versus phase 5. *Am J Obstet Gynecol* 1992;167:577-80.
4. Brown MA, Reiter L, Smith B, Buddle ML, Morris R, Whitworth JA. Measuring blood pressure in pregnant women: a comparison of direct and indirect methods. *Am J Obstet Gynecol* 1994;171:661-7.
5. Shennan A, Gupta M, Halligan A, Taylor D, DeSwiet M. Lack of reproducibility in pregnancy of Korotkoff phase IV as measured by mercury sphygmomanometry. *Lancet* 1996;347:139-42.
6. MacGillivray I, Rose GA, Rowe D. Blood pressure survey in pregnancy. *Clin Sci* 1969;37:395-407.
7. Gallery EDM, Brown MA, Ross MR, et al. Accuracy of indirect sphygmomanometry in determination of arterial pressure during pregnancy. In: *Proceedings of the International Society for the Study of Hypertension in Pregnancy IXth Congress, Sydney, Australia, Mar 15–18, 1994*. Monticello (NY): Dekker; 1994. p. 74.
8. National High Blood Pressure Education Program Working Group Report on high blood pressure in pregnancy. *Am J Obstet Gynecol* 1990;163:1689-712.

## Resource allocation and the Code of Ethics

In the article "Bioethics for clinicians: 13. Resource allocation" (*Can Med Assoc J* 1997;157[2]:163-7), Dr. Martin McKneally and colleagues state "The clinician's goal is to provide optimal care within the limits imposed by the allocation of resources to health care generally and to the institution, program and specific situation in which an individual patient is treated." Any physician who follows this advice would violate the CMA's Code of Ethics, the first canon of which is "Consider first the well-being of the patient."

The concept of resource allocation also raises the question of the fundamental nature of medicare in Canada. If we have state medical care, then despite the Code of Ethics one could possibly support McKneally's thesis. However, if we have medical care insurance, then the thesis is unsupported. Furthermore, in Saskatchewan we know that the coverage for physician services is insurance and not state medicine. A judicial ruling has said so.

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

Dr. Baltzan raises the central issue in resource allocation that troubles every caregiver. Does the physician's fiduciary obligation, expressed in the CMA canon discussed by Baltzan, require us to "do everything that may benefit each patient without regard to costs or other societal considerations"?[1] Can we simultaneously ignore the potential harm to other patients, including some we ourselves will be forced to treat suboptimally because of our earlier expenditure of finite resources? Our answer to both questions is No.

"Consider first the well-being of the patient" is a prima facie principle, one that provides sufficient moral guidance *at first view*, unless it is refuted or modified by other relevant facts, principles or contextual features. Just as we reluctantly harm patients when we perform a venipuncture to achieve a necessary benefit, we must reluctantly limit the allocation of resources to our individual named patients because the overall good of the community requires us to participate justly in the allocation of its resources. Morreim[2] has argued persuasively that physicians can generously dispense what is theirs to control and to give: their knowledge, care, skill and diligence. However, they must turn to society for dispensation of technological and other costly resources. Physicians are not members of a special class that has the right to allocate resources that they do not own and