chemical basis for the preferential impairment of hemostasis in hemophiliac patients, we might anticipate that patients with acquired bleeding disorders will experience a similar hemorrhagic tendency. Among those infected with HIV, such disorders could include idiopathic thrombocytopenia, chemotherapy-induced thrombocytopenia or the hemostatic deficiencies associated with liver disease.

Hemophiliac patients should be closely questioned for any change in their usual bleeding pattern while they are receiving protease inhibitors, as should any patients with other congenital or acquired hemostatic disorders.

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Applause for Dr. Romalis

Dr. Garson Romalis, whose story is told in the article "7:10 am, Nov. 8, 1994" (*CMAJ* 1998;158[4]: 528-31), by Anne Mullens, deserves applause. His courage in defending his beliefs and his vision for the future of abortion in Canada can at the very least be described as commendable but is probably more suitably characterized as inspirational. As an idealistic young man on the brink of his medical career, I too am drawn to obstetrics and gynecology. However, Romalis's ordeal leaves me asking why I should bother. When there are so many other ways to help my fellow human beings, why put my life on the line? For me the answer is clear: I hope I never have to practise medicine in a Canada where abortion is illegal.

The rewards of bringing a healthy, wanted child into the world are mirrored by the satisfaction of providing an essential and safe service to desperate young women. I have never assisted in more than the evacuation of an incomplete spontaneous abortion, and this means that I have not yet personally grappled with the emotional impact of the procedure. However, I have looked into the eyes of a distressed patient and seen the need. I may soon follow in the footsteps of "our greying abortion providers" and will actively support an educational symposium at McGill that is similar to the one described in this article.

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Advance directives for insulin-using diabetic patients

Advance directives are instructional comments written by a patient to guide health care professionals in the future health care of that patient and to designate proxy decision-makers should the patient become incompetent. The increasing use of advance directives is now governed by legislation in both Canada and the US.[1,2] Although most end-of-life treatment planning has been done in hospital, it seems that the outpatient setting provides a calmer atmosphere for this activity.[3]

Little has been written about the use of advance directives by patients with diabetes. We asked 27 insulin-using diabetic outpatients of both sexes (aged 18 to 70 [mean 49] years) to complete a questionnaire on demographic characteristics and their current knowledge of, attitudes about and behaviours regarding advance directives. The patients and their physicians also rated the patients' quality of life using Cantril's Self-Anchoring Striving Scale[4] and the patients' state of health on a numeric scale ranging from 1 (excellent) to 5 (poor). Half of the participants were then randomly assigned to participate in an education program on advance directives, which included a discussion and question period with a health care professional, an information pamphlet and a video entitled *My Health Care — I Decide*.[5] Four to 6 weeks later the patients were asked to complete a follow-up questionnaire.

All of the patients indicated that it was either extremely important or very important that they have a say in what type of health care they received. Eighty-nine percent of the patients believed that the best time to discuss their wishes was when they were well, during a routine visit. Thirteen percent of the patients reported at the outset of the program that they already had a directive. Those who participated in the education program showed increased knowledge of advance directives and reported increased discussion of their wishes with their family members and physicians. When patients were contacted 2 years later, 30% had actually completed an advance directive.

This small group of diabetic patients demonstrated a readiness to discuss advance directives with health care professionals *in the outpatient setting*, an approach that has been advocated as sensible and potentially cost effective.[1] Given that diabetic patients have significant and often predictable illness, specialist caregivers should be