



pragmatism or government insensitivity?" (*CMAJ* 1998;158[2]:213-4) together with my recent response to Dr. Byrne's letter should demonstrate that I am not a proponent of evidence-based medicine. Without denigrating the importance of scientific evidence in medical decision-making, I am concerned by the potential misuse of evidence-based medicine by politicians seeking support for rationing policies. If health care is to be rationed on the basis of research, governments should be expected to fund appropriate outcome studies that ask meaningful questions likely to yield answers that go beyond obvious issues of patient choice. Home care is a case in point. Although elaborate prospective studies are feasible, there is no routine need for evidence from cost-effectiveness studies to show that home care is preferable to hospital care in some situations. Furthermore, it is a basic premise of out-

come research that the right of patients to participate in treatment decisions must be respected as a component of quality of care and as a determinant of quality of life.

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Considering patient autonomy

The recent special issue on palliative care (*CMAJ* 1998;158[13]) was excellent. However, I was concerned that patient autonomy was not emphasized, perhaps because the aim was to encourage physicians to continue their interest in the patient, even when "cure" is no longer an objective. Yet the approach of a physi-

cian who follows a clearly stated protocol for palliative care may come into conflict with the principle of patient autonomy.

More often than not, the "health care team" does not include the patient. Instead, the team members come to an agreement on the approach to treatment and then discuss it with the patient. But what if the patient does not comply fully with the prescribed treatment? Patient autonomy should allow for this situation; indeed, the term is meaningless unless it does.

Patients differ in the degree of responsibility they wish to assume. We all depend on others for support and need their caring and love, especially during times of suffering and loss. This interdependence was beautifully described by Jennifer Raiche in her article, "Palliative care on the oncology ward" (*CMAJ* 1998;158[13]:1751). Dr. Jane Poulson discusses the



harrowing experience of knowing more than enough about her cancer in "Dead tired" (*CMAJ* 1998;158[13]:1748-50), But nowhere does she suggest that she would be willing to have others make her decisions for her. She made herself part of the treatment team.

Protocols for pain management are based on objective experience, but pain is subjective, and a patient may be willing to accept some degree of "discomfort" if reducing the dose of an analgesic agent also reduces nausea and improves clarity of mind. In her article "Ethical care at the end of life" (*CMAJ* 1998;158[13]:1741-7), Dr. Elizabeth Latimer draws a subtle distinction in accepting the harmful effects of an action, including the shortening of life, so long as the intended effect of the action is a desirable positive outcome, such as a restful state for a patient in distress. In cases of self-administration of medication, the patient can take more or less of the medication as required for comfort. In this situation, the patient might decide if, and when, a *permanent* "restful state" was desirable. Is this why patient autonomy is subscribed to more often in name than in fact?

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Placing the ads

The theme of the June 30 issue of *CMAJ* was palliative care. Following the usual pattern, the Editor's preface, by Neil MacDonald and John Hoey, highlighted articles related to this theme. Opposite the English-language version of the preface (*CMAJ* 1998;158[13]:1685) was an ad for Kadian, a long-acting morphine product, and opposite the French-language version (*CMAJ* 1998;158[13]:1687) was an ad for Duragesic, a transdermal fentanyl

product. Was this merely a coincidence, or did the advertisers have advance knowledge about the contents of the issue and request specific placement of their ads?

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[One of the authors responds:]

The CMA follows the directives of the International Committee of Medical Journal Editors (ICMJE), which state that "[j]uxtaposition of editorial and advertising material on the same products or subjects should be avoided, and advertising should not be sold on the condition that it will appear in the same issue as a particular article." As such, *CMAJ* avoids placing display ads next to scientific articles on related topics whenever possible. The Editor's preface often (but not always) discusses the contents of the issue, but the column is not a scientific article. It expresses the Editor's opinion of what is important or interesting that week, whether in the news or in *CMAJ* itself. The single pages opposite the Editor's preface and the *Mot du rédacteur en chef* are usually sold as "preferred positions" to advertisers, but for the June 30 issue, there were no requests for these positions. Accordingly, the only 2 single-page ads scheduled for that issue were placed there.

Details of articles and authors are kept confidential until publication. However, theme issues and continuing series are usually announced publicly in a call for papers or by soliciting contributions or both, and it is often widely known that *CMAJ* is going to publish a set of papers on a specific subject. *CMAJ* may provide advertisers with general information about subjects tentatively scheduled for upcoming issues, but details of the content, the names of authors and the confirmed editorial line-up are not revealed. Furthermore, display adver-

tising is not guaranteed to appear in an issue containing material on a particular subject.

CMAJ strives conscientiously to maintain both its editorial independence and an arm's-length relationship with the advertisers who financially support the journal. In the coming months we plan to review our advertising practices to ensure they are in keeping with the direction set out by the IMCJE and the current practices of international journals and Canadian medical publications.

John Hoey, MD
Editor-in-Chief

Talking about HIV

I agree with the recommendation that HIV testing should be offered to all pregnant women, as set out in the article "Evidence-based guidelines for universal counselling and offering of HIV testing in pregnancy in Canada" by Drs. Lindy Samson and Susan King (*CMAJ* 1998;158[11]:1449-57). However, as a family physician who is also a primary care provider for people with HIV, I think women would and should want to know their HIV status *before* they become pregnant. With the discovery of the remarkable benefits of zidovudine, more HIV-positive women are planning pregnancies. But the key word is "planning."

The health care issues for HIV-positive women are endless and not the focus of this letter. The point is that we, as family physicians and obstetricians who provide primary care to women, should be proactive. We should be asking women during their annual check-ups if they are planning a pregnancy (just because a woman takes a prescription for a year's worth of birth control pills doesn't mean she is going to use them all), and we should offer HIV testing when women ask if it's alright for them to