half the cases of assisted death are without consent — is the least supported. The evidence clearly does not permit such an interpretation.

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For the full letter, go to: www.cmaj.ca/cgi/eletters/182/9/905#532533

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In our article, the finding that half of cases of assisted death are performed without the patient's explicit request is very much supported by the data. There was patient consent or a patient's wish in some of these cases, but for the administration of life-ending drugs, this is legally not sufficient. A request or wish from relatives acting as surrogate decision-makers is also insufficient to justify such an act. But ethical and legal criteria aside, it is true that most decisions to administer life-ending drugs without explicit patient request are discussed between physicians and nurses as well as relatives.

In another study, also set in Belgium but surveying physicians instead of nurses, Chambaere and colleagues found that in only 6.5% of such cases, the physician had made the decision without consulting others.[1] The relatives were involved in 79.4% of cases, and other professional caregivers (colleague physicians or nurses) were consulted in 71%. Given these figures, it is safe to assume that a decision to administer life-ending drugs without explicit patient request is rarely made without some form of consent or agreement, be it from the patient, relatives or colleague caregivers. However, consent (even from the patient) does not constitute sufficient legal grounds to perform this act.

Our article focused explicitly on the role of nurses in decision-making and the preparation and administration of life-ending drugs in cases of assisted death with and without explicit patient request. Our questionnaire asked whether there was discussion between the nurse and the relatives in those cases — which happened in 68.9% of cases. We did not include this finding in the article because involving the relatives, especially in the case of patient incompetence, is ultimately the responsibility of the physician, as is the decision itself, with input from relatives and nurses.

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Increasing rates of flu vaccination in primary care staff

We recently reported on a randomized trial of a program to increase staff influenza vaccination in primary care clinics.[1]

As mentioned in the review by Lam and colleagues,[2] previous studies were in hospital and long-term care settings, and only one study had an arm in primary care (with an unsuccessful campaign). The difference between inpatient settings (hospitals and institutions) and outpatient settings (primary care clinics) is obvious but often ignored in the literature. The authors should have been more careful about generalizing analysis of data from staff in nursing homes to "nonhospital settings," which erroneously suggests that the conclusions also refer to primary care.

Our study showed that a promotional and educational intervention program can be highly effective in increasing the rates of influenza vaccination among staff. The campaign included local vaccination "champions," whose effectiveness was recently demonstrated in a hospital setting.[3]

Although we performed an intervention to increase rates of vaccination among staff, we think that the evidence about the benefits of such an intervention is weak. Lam and colleagues base the recommendation that all health care personnel should be vaccinated on a 2006 Cochrane review.[4] However, the Cochrane review concluded that there was no credible evidence of the benefit to elderly patients of vaccinating nursing home personnel.

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Ontario immunization rate for polio

The editorial about the polio outbreak in Tajikistan incorrectly states that immunization rates for polio in Ontario are between 70% and 80%.[1]

The most recent data from Ontario's Immunization Record Information System shows that 83% of 7-year-old children and 94% of 17-year-old adolescents are immunized against polio. Although immunization coverage rates for 7-year-olds have been relatively stable over the last decade, the rates have improved steadily by 17 years of age.

Under the Immunization of School Pupils Act, medical officers of health are required to maintain vaccination records of all school students for designated diseases. A written vaccination record or proof of vaccination is required by law for diphtheria, tetanus, polio, measles, mumps and rubella unless there is a valid written exemp-