

Quinine and leg cramps

We would like to respond to Hogan's commentary,¹ which states that quinine is not a safe drug in the treatment of muscle cramps. Hogan points out that nonpharmacologic and other pharmacologic options should be tried before prescribing quinine sulphate.¹ But, it is important to note that our previously published recommendations and guidelines² maintain a clear role for quinine when prescribed by physicians, and when adequate counseling is given to patients and adequate monitoring is in place. Simply calling a drug unsafe may lead to bans similar to those enacted in the United States, which severely limit options for neuromuscular clinicians who care for patients with disabling and terminal conditions such as amyotrophic lateral sclerosis.

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The author responds

I thank Katzberg and Breiner for their letter.¹ I do not believe that the use of quinine for muscle cramps should be banned, and I concur with the conclusion of the systematic review that Katzberg coauthored: "quinine derivatives for the treatment of muscle cramps should be avoided for routine treatment." Quinine derivatives should only be prescribed to patients who have been informed of the potentially serious adverse effects and "when cramps are very disabling, no other agents relieve symptoms, and there is careful monitoring of side effects."²

Our intent was to voice caution about the indiscriminate use of quinine for idiopathic muscle cramps in older patients, not to limit its use for patients with

conditions such as amyotrophic lateral sclerosis, who were excluded from the study by Garrison and colleagues.³

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We need a moral compass

Downie's commentary on physician-assisted suicide states that "as a profession we must ensure that there are physicians willing and able" to further this end once it is legal and regulated.¹ Over two millennia ago, the Hippocratic Oath described how the push to end our patients' lives was evident even back then: "I will not give a lethal drug to

obliged to medicalize suffering by making use of euthanasia, which corrupts end-of-life care³ and the treatment of hopelessness and mental illness.⁴

Many patients are searching for hope. This can be found in a therapeutic relationship that is genuinely caring and respects the value of a person's life, not only at the end of life, but also in conditions like depression and dementia. How can we as a society and a medical profession prevent suicide on the one hand and promote it with the other?

Conscientious doctors who do not want to betray their moral obligation to first do no harm nor to kill should not be complicit with the act of euthanasia by referring for it. Jurisdictions where euthanasia and assisted suicide are legal have acknowledged and respected the rights of doctors to act according to their consciences. Patients may transfer their files to another physician whom they have designated to carry out their wishes. As evidenced by legislation in Oregon, Washington, Vermont, Luxembourg, Belgium and The Netherlands, however, no legal obligation exists for a physician to perform euthanasia or to

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anyone if I am asked, nor will I advise such a plan."² Hippocratic medicine represented the dawn of principled practice, which is widely seen as the basis for Western medicine. Even then, they could see that just because they could do something didn't mean they should.

Modern medicine has not stopped searching for a solution to this timeless challenge. Modern palliative and psychiatric care and novel symptom management are among such endeavours. Even when faced with severe physical symptoms, doctors have ethical approaches at their disposition such as the use of sedatives for refractory symptoms at the end of life. Patients should always be comforted and doctors should not feel

refer the patient to another physician. Patients cannot demand euthanasia.

Faced with the spectre of forced participation in euthanasia and assisted suicide, Canada should enact similar legislation. Although this may result in travelling death clinics,⁵ the integrity of medicine could be preserved if we permit physicians the option to act ethically and first do no harm.

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Pocketbook versus patient

We read with interest the systematic review by Jenkins and colleagues.¹ Yes, imaging is sometimes overused and is a substantial financial cost for our publicly funded health care system.^{2,3} However, we question the utility of assessing interventions by measuring reductions in imaging referral rate. This yields information pertinent to cost-savings and does little toward balancing patient care. Referral rates are a poor surrogate for the more important and relevant outcomes of imaging appropriateness and patient-important outcomes (i.e., diagnostic yield and subsequent treatment outcomes).

An Ontario Ministry of Health bulletin, disseminated to all physicians in June 2012 stated that:

OHIP payment eligibility will continue to be limited to services that are medically necessary to the individual patient's circumstances, informed by the best available evidence. New language has been added to the Schedule of Benefits for Physician Services noting that studies of the lumbar spine should not be routinely ordered or rendered without suspected or known pathology ... If the diagnostic services were found to be not medically necessary in accordance with s. 18.2(1) and 18.2(2) of the Health Insurance Act, the physician requesting the diagnostic services will be responsible for repayment.⁴

Such an aggressive approach to reducing referral rates remains unparalleled in Canada. Threats of financial retribution against referring physicians are a dangerous precedent and could make physicians reluctant to order imaging regardless of whether it is needed. Such decisions would not be guided by concern for the patient but by the desire for cost-savings. This approach was shown to be ineffective in reducing referral rates.⁵

Though costly, imaging undoubtedly has value. We should not be guided by evidence conceived with cost-savings in mind but by evidence based on patient-important outcomes.

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Social equity in health care

Wong and colleagues observe two interesting and unfortunate findings in their study.¹ Individuals at higher risk of poor outcomes, including those with more comorbidities, are less likely to receive follow-up care, and those who visited a physician in the preceding year were more likely to receive follow-up care. This important work shows that medical need does not determine who receives follow-up care in a Canadian setting. Sicker patients may be less likely to see a physician for follow-up because of their "underlying conditions and the resulting restrictions in activity." Those who had not seen a

physician in the previous year represent a "vulnerable population."

There may be a more fundamental cause that could explain, in part, both primary findings. In 1971, Julian Tudor Hart, a Welsh general practitioner, proposed the "inverse care law," which states, "the availability of good medical care tends to vary inversely with the need for it in the population served."² The social determinants of health (when poverty and marginalization make people sicker) are largely the same as the social determinants of health care (when the same factors make good care harder to access). As a result, individuals who need care the most are least likely to get it, even in a publicly funded system.³⁻⁷

We appreciate the authors' conclusions, which advocate identifying and proactively retaining patients most likely to be lost to follow-up. We encourage readers to consider these findings at the level of our society and health care system.

If we want a system that effectively prioritizes and responds to medical need, it might be necessary to engage the underlying social, political and economic factors that determine who gets sick and who gets good care. In doing so, an effective health care system would also be a fair one, and a force for social equity.

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