COMMENTS AND RESPONSES

Ethics and Complementary and Alternative Medicine

TO THE EDITOR: Adams and colleagues (1) show us how to deal with complementary and alternative medicine (CAM) in a legally, ethically, and politically correct fashion. Despite all this, Ms. P., the patient in Case 1, is likely to develop cancer and die. This outcome would result not only from her preference for CAM over conventional therapy but also from the failure of her health care team to convince her otherwise. Significant proportions of CAM providers advise their clients against certain conventional treatments (2). To some degree, this reflects the failure of conventional medicine to get important messages across. If Ms. P. dies, she also dies of our political correctness in dealing with ill-conceived concepts within CAM and of our failure to adequately reason with CAM providers. A complete risk–benefit analysis should account for the paucity of good communication between the two camps. And truly ethical behavior should include serious attempts to improve this situation.

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References

IN RESPONSE: Professor Ernst raises an important question: How can we improve communication with CAM providers to promote our patients’ understanding of their situation and options? Clearly, in the case of Ms. P., surgery would be life-saving, and ideally her CAM providers as well as her allopathic providers would encourage that choice. But as Professor Ernst notes, CAM providers are not always open to allopathic treatments or to partnering with allopathic providers, just as allopaths can be resistant to collaboration with CAM providers.

A truly integrative health care system would encourage such collaboration to the benefit of all concerned, and should be a primary goal as relationships between CAM and conventional providers evolve. I am convinced, however, that Ms. P. made her (fully informed) decision on the basis of her own values, not those of any of her providers, as evidenced by her statement, “Even if you told me I would die tomorrow without surgery, I still wouldn’t have it.” Therein lies the crux of the matter, and indeed, the dilemma for all providers when faced with a refusal of their carefully considered recommendations. Ms. P.’s decision was based on her own assessment of her options, and the influence of her health care provider was only one factor in her assessment.

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Correction: Malignant Glioma Physiology

In a recent review on malignant glioma physiology (1), an error appeared at the end of the first full paragraph in the second column on page 633. The sentence “The enzyme that hydroxylates HIV-1α and blocks the interaction between HIF-1α and CBP/p300 is an asparagine hydroxylase” should read “The enzyme that hydroxylates HIF-1α . . . .”

Reference
Urinary Catheters: A One-Point Restraint?

TO THE EDITOR: I read with great interest the editorial by Saint and colleagues on indwelling urinary catheters (1). As indicated by the studies referenced by the authors, particularly those by Beeson (2) and by Platt and colleagues (3), we have understood the danger of this procedure’s significant complication rate, as well as the inconvenience and pain it causes, for more than 40 years. Clearly, thousands of people have died unnecessarily because of this procedure.

I believe all physicians endeavor not to use restraints unless they are absolutely necessary. There are exceptions, of course, and adverse outcomes have infrequently resulted from restraints. Currently, the regulatory environment is such that hospitals devote an enormous amount of effort to restraint adherence. It is almost certain that a similar level of effort at reducing the frequency and duration of urinary catheterization would yield substantially more important results. In a world with finite resources, perhaps we ought to pick improvement projects more carefully to provide better care for our patients.

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References

A Lesson in Poverty

TO THE EDITOR: Dr. Das’s account of her experience on returning to India after training in the United States highlights the challenges faced by many foreign-trained doctors seeking to relocate to their countries of origin (1). Integrating returning foreign-trained physicians into an environment that is demographically distinct from that of their most recent practice is complicated by the fact that most developing countries do not have the planning and organizational resources to efficiently utilize new and innovative skills. Foreign-trained doctors returning from some European locations not infrequently become “deskilled” because of less structured and inappropriate-caliber training for their level of seniority (2). This, in turn, may impede a speedy integration into the local medical community. The period spent abroad may also sever social ties with fellow medical professionals, hindering initial efforts to establish a clinical practice. Returning physicians often underestimate their own personal metamorphosis of perspective on many issues, which creates a potential source of conflict and disillusionment.

Experience suggests that tact and social skill are crucial to successful integration in less receptive, more competitive, or occasionally hostile settings. When properly reassimilated, however, foreign-trained physicians may provide channels for international research corroboration, technology transfer, and organizational skills that are crucial for development. The challenge for many developing countries and returning foreign-trained physicians is to adapt newly acquired expertise to public health and social development. The consequences of foreign training clearly encompass broader issues beyond medicine.

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References