PostScript

LETTERS

A patient's choice

Lilly has a story to tell. It is her story. She sits comfortably in her hospital bed, with a nasal cannula under her nose providing a steady stream of oxygen. She says she really does not need it now but is more comfortable with it. She straightens the hem of her hospital gown. She folds her hands and places them carefully on her lap. This diminutive, carefully groomed elderly woman, a widow for 7 years, likes to be presentable when she has a guest.

"Please sit down," she says, pointing to the chair. She would be no more inviting if we were in her own living room.

"You're in the hospital. What happened?"

"Heart problems", she says. "Heart failure. I've been sick for years. I'm old, my heart is old. When it gets bad I have to struggle to breathe."

"Is that what happened this time?"

"I didn't know it was happening this time," she says with some surprise.

"I am very active. I go out every day, I do my shopping, cooking. I like to cook. I was walking. It started. The hill is very steep from the avenue to my house so I made nothing of it. Out of breath. I took my time, rested and then walked again. It was also hard for me to walk up the four flights to my apartment. I stopped every few steps. So what? An old lady getting tired and out of breath. Nothing new about that. I missed all the signs. Sonya didn't. She's a neighbour and when she saw me she said what she was seeing wasn't right. I don't know what she saw. I do know how I felt. I was getting sick again. I remember the ambulance, the siren, having a real hard time getting air in, and then nothing until I heard my nephew's voice through the fog from all the medicine they gave me. They said I was trying to pull out the tube that connected me to the respirator. They tell me I had been in the ICU for 2 days when Anthony finally got to the hospital."

Senior medical residents care for critically ill patients in intensive care units. They are always there; there is always something to do. The tempo lessens on weekends and especially at night when senior doctors are no longer making rounds and families have gone home. It is Saturday evening, a quiet time,

and Lilly, who is in the unit on a ventilator and receiving intravenous drugs to get her out of heart failure, is starting to respond to the treatment. She is restless, pulling at her lines. She motions to the hard plastic tube in her mouth. She wants it out. She reaches for it. She will do it herself. The doctor grabs her hand. The nurse increases the sedation. She needs to be on the respirator until the heart failure, congestive heart failure, is under control. It is only then that she can safely be removed from the machine.

Lilly's nephew appears at the hospital at 9:30 in the evening. He insists that he be brought to his aunt even though visiting hours are over. She is critically ill, in intensive care, he has just arrived from Texas, where he lives, and has to see his aunt now.

Anthony, in his mid-50s, with a burly chest, thick neck and a working man's hands, bursts into the intensive care unit, an envelope in hand, and asks to see his aunt. It takes no more than a second before he demands that the doctor remove the ventilator. "I am my aunt's proxy," he says, as he removes the document from the envelope and hands it to the doctor.

What to do? It is 21:30 on a Saturday and this man is asking the medical resident to do something that may immediately result in a patient's death. Calls are made, first to the consultant for the hospital's ethics committee and then to the patient's private doctor. Nothing should be done tonight. Sedation may be the cause of the patient's current lack of capacity. When she comes off it she may be able to make her own decisions. It is premature for the proxy to make decisions. And if there comes a time when we turn to the proxy, he will have to give informed consent and that means a discussion with Lilly's private doctor. Nothing will happen before the morning, when the doctor will be in the hospital and will examine her.

Anthony will have none of this. The moment he knew his aunt was in hospital he made arrangements to be there. It was his promise to Lilly. "You will be so far away," she said when he told her he was moving to Texas. "What if I get sick?" was her worry, now that she was 80-years-old and was starting to have problems with her heart. "Nothing is so far that I can't be here in a day." This was what he promised his aunt and he has her proxy in his hand. He tells the doctors that he knows what she wants and what he is seeing in the intensive care unit is not it. Tomorrow is not soon enough. Do it now. Remove the ventilator now. He knows the law, he knows Lilly's rights and the rights she conveyed to him by completing a health proxy. "No is not an answer." He is a nurse, he says, his sister works for an agency that accredits hospitals, we are wrong, we will be held accountable, he wants to speak to whoever is in charge!

Saturday, now 23:00, visitors have long since gone, and there are critically ill patients needing constant care; there is neither time nor patience for Anthony, who will not relent. The nursing supervisor and the night administrator, the people in the hospital who are in charge, and the administrators they have paged when an issue must be dealt with immediately hear the story and support the

decision; the patient will not be removed from the respirator at this time. At 02:00 Anthony leaves the building. He is enraged that his aunt's wishes are being ignored. He will come back on Sunday and get done what should have been done tonight.

Lilly, in her hospital bed, becomes more animated as she retells the drama of Saturday night. "I remember," she says, "that my nephew came and told them to what to do and when they wouldn't, he told them a thing or two. Do I know what it was about? Of course. That machine, he wanted them to take the damn thing off."

"The doctor took the tube out on Sunday. He came, asked me questions and then asked the same questions again and when I wouldn't give him any other answer, he finally turned off the machine and took the tube out. What questions? Stupid questions. Do I know where I am and why I'm here? Do I know what the machine does? Do I know what could happen without it? Do I understand that I could die without it? Yes, yes and yes. It's my heart that has ten percent left that works, not my brain."

"Well, you've made it. No machine and you are alive"

"So I am."

"What next?"

"A little rehab and then I want to go back home. I'll need someone to help me with shopping and taking care of the apartment."

"It seems like you're very much in this world. I've enjoyed speaking to you, and it seems you with me."

"Absolutely."

"So the respirator was a treatment, not something you'll need forever. Your doctor thought you needed the help breathing until the medicine got you out of heart failure. What do you want the doctor to do the next time you run in trouble?"

"The same thing I wanted him to this time."

"And that is?"

"I don't want to be on the respirator."

"But look at you Lilly. You are still so much alive and all it took was three days on the machine."

"I love life, and I'm not afraid of death. Ten percent, that's all that's left of a very old and sick heart. No respirators. This will happen again and the next time it happens, they can give me everything but don't put

me on anything. My time is coming and that will be the end. I'm ready for it and you and the doctors have to be ready for it too."

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The generic-patent medicine conflict flares up again in The Netherlands

Recently I reported in this journal¹ how it became necessary for a judge to settle a dispute between the pharmaceutical industry and certain Dutch pharmacists. It considered the question of whether a pharmacist is permitted, without prior consultation, to give a patient a (cheaper) generic drug instead of the patent drug mentioned on the prescription.

Another dispute has now arisen after the pharmaceutical industry discovered that healthcare insurers were paying general practitioners (GPs) a bonus if they prescribed generic drugs, such as simvastatin (which reduces cholesterol content) or omeprazole (which reduces the production of gastric acid), instead of the more expensive patent forms (Zocor and Losec, respectively). According to the national newspaper, *Trouw*,^{2,3} Menzis, one of the largest healthcare insurers, offered each of 2300 GPs up to €8000 annually if they switched their patients from patent drugs to the equivalent generic forms. Since the offer was made, more than 160 GPs have agreed to comply with this condition. If most GPs follow this example, Menzis hopes to save more than €3 million each year. GP Geert van Loenen and five other doctors,⁴ however, have rejected the offer and are annoyed that their colleagues "have sold themselves in such a way to the insurer". At the same time four of the leading drug companies; Pfizer, Merck, AstraZeneca and Altana, have taken legal action against Menzis. One of their main arguments was that there existed a code which stated that insurers were not permitted to influence the medical profession on how to treat their patients. On 14 October 2005,⁵ a judge at the law court in Arnhem decided otherwise. He concluded that the competition that exists between insurers since a recent law on health insurance was approved by the Dutch parliament has changed the system. It is in the interest of the insurers to offer their patients the lowest insurance rates. This may entail the payment of a bonus to the GP as long as the patient is not the worse for it. The GP has the right to determine what drug he wishes to prescribe. Furthermore, the code (mentioned above) was not devised for the purpose of protecting the pharmaceutical industry.

According to the newspapers, the Royal Dutch Society of Medicine is surprised at the judicial outcome and a number of patient

organisations are disturbed by the judge's decision. The pharmaceutical companies are now considering whether they should take the issue to a court of appeal.

In my opinion, there exists here a difference between a legal and an ethical solution to the conflict. I believe that it is unethical for a physician to accept a bonus from an insurer. I hereby express my admiration for those GPs who have declined to sign the contract with the insurer, Menzis.

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Consent for anaesthesia in cataract surgery

Cataract surgery has evolved rapidly over the last decade. Previously such cases required admission for prolonged postoperative convalescence. However, currently such procedures are carried out as day cases. An area where significant change has evolved is the role of anaesthesia in cataract surgery.

Recently, a growing number of surgeons have been performing cataract surgery using topical drops to achieve anaesthesia. However, case selection and operator experience impose a limit on the use of topical anaesthesia.¹ Other local techniques for delivering anaesthesia include sub-Tenons and peribulbar block, although a minority of patients might require sedation or even general anaesthesia to achieve anaesthesia.

The consent of such patients is an area of concern. While complications such as retrobulbar haemorrhage, globe perforation, muscle injury, and brainstem anaesthesia occur only rarely, nonetheless the outcome might have serious implications with regard to the visual outcome, or could even be death. In some cases where sedation is necessary during the procedure, formal consent might not have been obtained. Furthermore, appropriate advice—for example, fasting in cases of planned local block—would not, in such circumstances, have been given to the patient.

A survey of 23 ophthalmic surgeons (all grades) who routinely perform cataract surgery (West London ophthalmic units) revealed that up to 80% of surgeons do not obtain formal consent for local anaesthetic procedures and a further 86% do not discuss the options of local anaesthesia with patients. However, about half of the surgeons do mention the option of general anaesthesia during the outpatient visit.

The high number of surgeons failing to obtain consent is despite the recommendations of the Royal College of Ophthalmologists (RCO), which state that surgical assessment should also include discussion of the type of local anaesthetic for each individual patient.²

Currently, it is usual for a tick box system on the consent form to indicate the type of anaesthesia (without indicating the type of local technique) the patient is to receive, with an informal consent being taken verbally by the anaesthetist or the surgeon administering the block.

According to the guidelines of the Royal Colleges of Anaesthetists and Ophthalmologists³ a separate consent sheet is not necessary for the anaesthetic part of the procedure.

However, a separate consent form and a standard method for discussing the options of anaesthesia in the outpatient clinic could avoid unnecessary litigation and ensure that all the appropriate options had been offered to patients in good time before having cataract surgery.

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BOOK REVIEWS

The Trust Prescription for Healthcare: Building Your Reputation with Consumers

Edited by D A Shore. Health Administration Press, 2005, \$63.00, pp 165. ISBN 1567932401

Taking a phrase from President Clinton's successful presidential campaign in 1992, this book could have just as easily been called *It's About Trust, Stupid*. In his book, David A Shore, PhD, associate dean and founding director of the Trust Initiative at the Harvard School of Public Health, presents