nized 3-hour time barrier from symptom onset, effectively limit stroke thrombolysis to tertiary care centres (which provide a minority of emergency medical care in Canada). Practitioners in non-tertiary centres must be aware of the risks and limitations of stroke thrombolysis so that they can provide their patients with the best local standard of care and "do no harm."

Gubitz and Phillips correctly point out that low molecular weight heparins (LMWH) are unlikely to benefit patients with acute stroke. Although one study[4] showed impressive results in this setting, these results have not been replicated elsewhere, and a recent Cochrane Review (published after the *CJEM* Journal Club article went to press) concluded that, although LMWH appears to decrease the occurrence of deep vein thrombosis, there are too few data to provide reliable information on their effect on other important outcomes, including death and intracranial hemorrhage.[5]

The Cleveland study demonstrates that outcomes achieved in research settings may not be reproducible in all settings. Until such time as community-based effectiveness studies demonstrate safety, emergency physicians should remain skeptical. In the wrong hands, tPA may cause more harm than good for acute stroke victims.

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Prehospital DNR orders: an ethical dilemma

To the editor:

Thanks to Sherbino and colleagues[1] for addressing the important topic of prehospital do-not-resuscitate (DNR) orders. They make a number of excellent suggestions, including the need to develop clear policies, adopt standard DNR forms, improve public education and improve the emergency medical technician's (EMT's) access to on-line control.

A significant problem is the lack of published data on Canadian emergency medical services policies. In British Columbia a standard DNR form has been developed, and EMTs are authorized to honour it in the field.[2] Nova Scotia is now developing policies to allow paramedics to honour DNR forms. At present, they have access to on-line control and may honour a DNR form with base physician approval. Other provinces may have similar policies but few are published, leaving each region to reinvent the wheel. Ontario has unique problems related to specific legislation. With a forum like *CJEM*, emergency medical services (EMS) directors and policy-makers could share their experience with others and address these problems at a national level.

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Fee-for-service remuneration

To the editor:

Your editorial[1] in the October issue of *CJEM* appropriately highlighted some of the problems associated with fee-for-service (FFS) payment plans. One of the biggest problems with FFS in any branch of medicine is that it encourages financially motivated physicians to produce "doctor dependent patients," encouraging, for example, visits for self-limiting viral illness and unnecessary re-checks. This flies in the face of the current philosophy of making patients (or, should we say, people in general) more responsible for their own health care and status.

One aspect of your editorial might, however, suggest to FFS emergency physicians that their lives will become significantly easier with alternate funding arrangements (AFA). Like you, we work under an AFA in a high volume, high acuity setting. We are (relatively) happy with our earnings, and our coverage is (reasonably) adequate. We do not, however, have "more time to spend with patients in the trauma room," we still work long shifts without eating, drinking (or, for that matter fulfilling the other end of the oral intake arrangement). We still have 17 decisions hanging over our heads, are constantly bickering with admitting services and disgruntled patients, and the "short snapper" patients are still the most desired because their beds can be freed more quickly. It is the rare shift that we are reminded how much we enjoy our job by an interesting and challenging patient presentation, or even an enjoyable procedure — more often, we are obliged to refer the patient, for whom our skills were developed, so that we can continue to wade through the hordes of undifferentiated

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patients climbing onto the conveyor belt.

FFS should die, and soon, but there are many other systemic issues that will need to be resolved before our longevity is increased.

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1. Innes G. Eat what you kill [editorial]. CJEM 2000;2(4):228.

Correction

In the CAEP Annual Scientific Assembly Abstract Submission Information,[1] published in the October 2000 issue of *CJEM*, under the subheading "Abstract review process" the CAEP Web site should have been listed as www.caep.ca

We apologize for this error.

Reference

1. CAEP Annual Scientific Assembly, Calgary, Alberta, March 21–24, 2001. Abstract Submission Information [news]. CJEM 2000;2(4):280-1.

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