or lighten it up to get a better idea of where the patient’s at,” says Librach.

Caution is particularly necessary when assessing a patient for continuous palliative sedation therapy to treat nonphysical suffering, says Blair Henry, a clinical ethicist at Sunnybrook Health Sciences Center in Toronto, Ontario, and a member of the team drafting the framework. “It’s rare that such suffering would be called intolerable and refractory, but it’s part of everyone’s practice experience that you do occasionally meet people who are in such distress or crisis that no intervention of a psychologist or chaplain or any team member can relieve.”

While such cases are most commonly confused for physician-assisted suicide, withholding treatment, as a rule, would not be appropriate, says Librach. “I find it very difficult to separate out. In one case, I knew my patient was going to die a very difficult death with his bowel perforating but up to that point he wouldn’t have much pain. He told me he was suffering waiting for the end, and I told him we would sedate him when the time came. We never were able to control his pain at end-of-life. He has this acute event, no one was standing by his bedside at the ready, and I’ve felt guilty ever since because he died a quick but very horrible, painful death.”

Although patients regularly “walk away from the treatment table,” refusing chemotherapy or dialysis, a patient’s ability to “walk away from their sentence” is decidedly more limited by societal pressures, says Henry. “We’re holding people from therapy they may in fact need because of value judgments we’ve made that a person should find meaning in their suffering.”

The draft framework will be submitted to the Canadian Society of Palliative Care Physicians for review in the coming months. A final version will be published in 2011. — Lauren Vogel, CMAJ

CMAJ 2011. DOI:10.1503/cmaj.109-3766

Infectious risks in family doctors’ offices

What a difference a year makes. During pandemic (H1N1) 2009, primary care providers were scurrying around offices and clinics removing books and toys from waiting rooms, positioning bottles of hand sanitizer, passing out surgical masks to patients who presented with a cough or fever and using hospital-grade disinfectant to mop up floors when a suspected H1N1 case left their office or clinic.

They were, of course, following infection control guidelines established and recommended by the College of Family Physicians (CFPC) and a number of other groups during the height of the pandemic.

As the threat fades into memory, there’s an understandable tendency to hide the mops in the closet and leave the masks in the box.

But Ontario’s top infectious disease doctor is urging primary care providers to maintain aggressive infection prevention and control measures in their practices year-round.

Returning to business-as-usual would be a mistake, says Dr. Doug Sider, acting director of infectious disease prevention and control for the Ontario Agency for Health Protection and Promotion. “To recommend that we only consider more aggressive compliance with all of these infection prevention and control measures in the face of something like pandemic influenza, and then step back, relax our vigilance, relax our expectations, relax our urging to compliance at other times, just doesn’t make a lot of sense to me.”

The CFPC has never developed infection prevention and control guidelines for standard family practice. Although it was one of the associations responsible for developing and issuing the guidelines during the pandemic (along with the Canadian Medical Association, the National Specialty Society for Community Medicine and the Canadian Public Health Association), those do not apply outside of a pandemic, says Jayne Johnston, the college’s communications manager.

The college doesn’t have a general infection control policy telling members how they should, or should not, run their practices on a day-to-basis, Johnston says.

But some of those recommendations would be good practice year-round, particularly as the flu season descends, says Sider, who suggests that primary care doctors always ensure staff is immunized with the seasonal flu vaccine and that standardized procedures be adopted for hand hygiene and the conditions in which masks should be used.

Sider also urges regular screening for febrile respiratory illness and depending on office design, the adoption of measures to contain its spread, such as asking patients who present with a cough and fever to sit in one part of the waiting room. As an alternative, staff can use a telephone triage system to screen for respiratory illness and then cluster those appointments near the end of the day, he adds. That would limit transmission and allow for the office to be sanitized properly before the next business day.

Such measures are a challenge for many family practices, Sider acknowledges. “It’s easy to say, but it’s really hard to put into place. Hospitals have environmental services people that can
National home care standards urged

Home care has become one of the fastest-growing areas in Canadian health care over the past decade, though, as is often the case in Canada’s fractured health care landscape, some provinces are performing better than others.

It is difficult, however, to compare the state of home care in different jurisdictions because the very notion of home care differs from province to province. This is why, according to Marg McAlister, a project manager for the Canadian Home Care Association, Canada needs a set of national standards for home care. “It is hard to compare province to province because each defines the roles of various professions in home care differently,” says McAlister.

The most comprehensive look at home care across Canada can be found in the Canadian Home Care Association’s Portraits of Home Care in Canada 2008 (www.cdnhomemc.ca/media.php?mid=1877), an update of a 2003 report that gave home care leaders the opportunity to “have their voices heard through their descriptions of home care as it is known and understood within each of their respective jurisdictions.” Though the document warns that “valid comparisons cannot be made because of the absence of data definitions and the variation of data collection and reporting across Canada,” it does offer “snapshots” of home care programs, which highlight such features as governance, organization, services, quality and accountability (Table 1).

With respect to governance, there is little variation across the country, with 12 of 13 provinces and territories operating home care services under the jurisdiction of their ministries of health. The lone exception is New Brunswick, where home care is run by the New Brunswick Department of Health and Wellness and the New Brunswick Department of Social Development.

Legislation for home care, on the other hand, varies widely — tucked into various acts, orders-in-council, guidelines and policies. “This lack of a specific legislative framework for home care contributes to the wide variation in access and availability of services across Canada,” the report states.

In terms of services, almost all jurisdictions offer core services such as case