College of Emergency Physicians announced\(^1\) that they are jointly working on documents regarding the application of family-centered care as it pertains to the death of a child in the emergency department. A recent review of peer-reviewed manuscripts\(^4\) shows a clear trend in favor of FWR, especially by families, followed by nurses and experienced physicians. This review pointed out the limitations in the published literature. Many FWR articles did not test a hypothesis, and broad conclusions were made from weak data. Clearly, more work is needed before FWR can be advocated wholesale.

In the mean time, increased discussion and study may enhance the opportunity for and acceptance of controlled FWR in many settings. When done correctly with appropriate staff liaisons, the practice of FWR can be very rewarding. Many parents have thanked my colleagues and me for allowing them to be present during their child’s precious last moments. They were present at the beginning of the child’s life. They should be allowed to be present at the end!

LTC Kevin M. Creamer, MD, MC, USA
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References


To the Editor:

We thank Dr. Creamer for his interest in our article, and we acknowledge his expertise in pediatric intensive care and family-witnessed resuscitation (FWR) for pediatric patients. We agree with Dr. Creamer that pediatric medicine, by its very nature, requires a more family-centered approach, in which there is continuous interaction between health professionals and parents functioning as guardians and decision makers.

In our original article, we stated that the results of opinions toward the pediatric patient should be interpreted with caution, as only 20 of the 494 physicians surveyed were trained in pediatric specialties. We warned that our pediatric resuscitation data might not reflect the opinions of the larger community of pediatric intensivists. In fact, Dr. Creamer’s published data show that he and many other pediatricians have embraced FWR with great success and satisfaction.

Our survey data did not show a statistically significant difference of opinion toward FWR of children when pediatric-trained health-care professionals were compared to adult health-care professionals (26.1% vs 14.2%, respectively; p = 0.138); however, the subgroup of 12 primary pediatricians was more likely to favor FWR for children compared to adult-trained health-care professionals (41.7% vs 14.2%, respectively; p = 0.022). While subgroup analysis supports Dr. Creamer’s position, we believe that the number of pediatricians we surveyed was too small to draw definitive conclusions.

In summary, we agree with Dr. Creamer that this area requires more research and discussion before FWR can be “advocated wholesale.” In the interim, hospital leaders should consider each patient and family situation individually and should ensure that physicians and nurses are trained to support FWR in appropriate circumstances.

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Clarifying Cardiac Decortication Procedure

To the Editor:

I read with interest the article by Byrne et al in the December 2002 issue.\(^1\) I have two questions regarding management of this difficult patient cohort.

First, in the cases in which the parietal pericardium was excised on the left side, was Gortex (WL Gore; Sunnyvale, CA) or other material used to close the pericardium? Might replacing the pericardium, which is usually not recommended, prevent this complication or at least lengthen the interval until it occurred?

Second, it appeared that the patients who had positive histology results or histology demonstrating tumor recurrence on reoperation had a much poorer survival rate. If there was tumor present on the frozen section, should the cardiac decortication be aborted?

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Reference

To the Editor:

The use of a Gore-Tex (WL Gore; Sunnyvale, CA) membrane to reconstruct the parietal pericardium after right extrapleural pneumonectomy (EPP) is routine, so as to avoid cardiac herniation. However, as Dr. Baciewicz rightly states, it is rarely used after left EPP. Dr. Baciewicz’s suggestion to use Gore-Tex after left EPP to attempt to prevent this complication, or to at least delay its onset, seems like a reasonable idea. Although we have anecdotal experience with this approach, we have not observed any meaningful difference in outcome.

With regard to tumor recurrence, since the palliative operation is principally performed to relieve symptoms of shortness of breath and fluid overload, we have not attempted to determine whether or not the fibrous scar overlying the myocardium is tumor, as this finding would not change our plans to at least attempt deortication.

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Increasing Statistical Accuracy

To the Editor:

I was pleased to read the article by Moss and colleagues in the March 2003 issue. As a professional epidemiologist and biostatistician, I can only welcome any press that may increase the need for the services of my profession. I agree that too many readers take the presented methodology and reported statistics on good faith. In fact, a certain amount of faith on the part of the reader that the investigators have performed an exhaustive and thorough statistical analysis is inherent.

This letter is directed to the question of how investigators can increase either their own individual statistical knowledge or can increase the accuracy of statistical reporting. The answer is to increase one’s own knowledge or to solicit the help of a trained analyst. Self-study on the part of the physician is certainly an option, and no shortage of statistical texts exists, but what physician has the time? Formal academic training is an option, but, again, the issue of time, and more importantly, the topics discussed by Moss et al, are not readily covered in depth until the third or fourth class in a given course series. Furthermore, faculty probably would not be inclined to let individuals skip ahead.

The solution may be simple. Contact an epidemiology or biostatistics faculty member at a local academic center. For physicians already at an existing center, this should be no problem. I trained at the University of South Florida where the School of Public Health is less than 500 yards from the School of Medicine, the School of Nursing, and the local Veterans Affairs hospital. Biostatistical academicians still must “publish or perish.” Graduate students need experience and, more importantly, curriculam vitae exposure. For physician researchers at nonacademic centers, this issue is bit more complicated. Funding may be an issue, but I think physicians would be surprised at how far an offer of authorship would go.

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REFERENCE

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Another View of End-of-Life Care

To the Editor:

I am a graduate student in nursing at the University of North Carolina at Chapel Hill in the Adult Nurse Practitioner program, with a focus on Cancer/HIV/AIDS. I am responding to the article by Curtis et al in the July 2002 issue. I would like to commend the authors for providing a much-needed patient perspective on end-of-life (EOL) care. All health-care providers need to learn more about the issues involved in EOL care and, particularly, to pay attention to the patient/family perspective that was provided in this article.

The authors’ findings that patient needs and treatment vary depending on the disease process of the patient who is dying is very necessary information for those of us involved in EOL care. The similarities found concerning the issues that are important to patients, no matter what their disease process, such as the importance of emotional support, communication, accessibility, and continuity, will help to guide our future EOL care. It was unfortunate that the authors found that the group of patients with COPD was dissatisfied with education about EOL care by their physicians, including advance care planning. These patients also thought that physicians did not understand their EOL medical care preferences.

Tannelle2 found that a quarter of all nurses who responded to his survey had seen clinicians purposely ignore patients’ wishes as stated in their advance directives, even when these wishes were understood. Therefore, it is of the utmost importance that all clinicians (ie, nurse practitioners, doctors, physicians’ assistants, and nurses) give special attention to this area of education and care; starting in primary care settings when patients are well, and including inpatient hospital care and hospice care.

There have been many studies performed concerning EOL care; however, there have not been as many giving the perspectives of the patients, thus making this a highly valuable study, as the authors state. It is important as health-care practitioners that we not only discuss how we feel about this subject among ourselves, but is also highly necessary that we hear the patients’ opinions on it. It is also important to examine their families’ experiences in the hopes that health-care personnel can “avoid miscommunications and decisional conflict and facilitate more positive outcomes.” This would, in turn, help to improve patient satisfaction with EOL care. We must, as practitioners wishing to improve care, include family satisfaction as well as that of the patients in the process of care. Haddad3 has said that it is important that families feel that their loved ones received their...