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 decortication.

John G. Byrne, MD, FCCP
David J. Sugarbaker, MD, FCCP
Harvard Medical School
Boston, MA

Increasing Statistical Accuracy

To the Editor:

I was pleased to read the article by Moss and colleagues in the March 2003 issue.1 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 think of statistics as being placed in either the first or last quarter of a course series. Furthermore, faculty probably would not be inclined to let individuals skip ahead.

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, curriculums 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.

Scott D. Barnett, PhD
Inova Heart Institute at Fairfax Hospital
Falls Church, VA

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.1 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.

Tammelleo2 found that a quarter of all nurses who responded to her 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.”3 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. Haddad4 has said that it is important that families feel that their loved ones received their...
last wishes ‘because it was their right.’ It is our duty as clinicians to hold our patients’ rights in high regard. The findings concerning how doctors can improve EOL care are equally important to those concerning advanced practice nurses who work in this area, as we all have the same goal of improving EOL care. During the dying process, the principle of autonomy would suggest that it is essential that families and patients be in control. In our findings and our practice, we must collaborate with physicians in this highly sensitive area of patient care in order to best discover and implement EOL care that will enable our patients to achieve autonomy. I urge all clinicians, whether they are doctors, nurse practitioners, physician’s assistants, or nurses, to learn as much as they can about EOL care and to share and implement their findings in this area with each other. We must remember that our first priority is to the patients and their families, and that we are truly privileged to share this most sensitive time of their lives with them.

Catherine K. Nakayama, RN
University of North Carolina at Chapel Hill Graduate School
Chapel Hill, NC

REFERENCES
2 Tammelleo AD. Protecting patients’ end-of-life choices. RN 2000; 63:75–77
4 Haddad A. Acute care decisions: ethics in action. RN 1997; 60:17–19

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