

Having read both sides of the debate, I think that Dr Vinay doesn't offer much of a strong argument against palliative care as a specialty.¹ Specifically, to say that we will rally exclusively to those physicians with a focused area of practice is not a strong enough argument. If this debate occurred 10 to 20 years ago, then yes, the issue would be totally different. But now, medicine is increasingly multidisciplinary. More than ever, we need to work together as a team in managing the whole spectrum of our patients' needs.

Bottom line: we need to work as a team of health professionals and understand our limits. Family medicine physicians are known as the expert generalists of all fields equally. Realistically, this means we individually have some areas of practice that we are less comfortable with, and others in which we are more proficient.

Family medicine-focused areas of training are necessary to enhance our knowledge in particular fields, whether they be palliative care, sports medicine, geriatrics, obstetrics, or any other areas of care. In the end, this will work toward increasing the quality of care delivered to our patients.

—Jean-Claude Quintal
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by Rapid Responses

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Hypercalcemia

In the June 2008 issue of *Canadian Family Physician*, Dr O'Brien provides a concise and practical review of the treatment of nausea and vomiting in palliative care patients.¹ Still, I would like to take an opportunity to clarify and expand on 2 statements that were made on the topic of hypercalcemia.

First, "Hypercalcemia should be anticipated in patients with bone metastases." Hypercalcemia of malignancy (HCM) occurs in patients with or without osteolytic bone metastases.² In particular, many tumours that frequently develop bone metastases (prostate, small cell lung, and colorectal cancer) are rarely associated with HCM.³

Anticipating HCM involves taking into account not only the presence of bone metastases, but also the primary tumour location and histology. Breast, lung, and head or neck cancers are common primary tumour locations and squamous cell and adenocarcinoma are common histologic subtypes.⁴ Of the hematologic malignancies, multiple myeloma is frequently associated with HCM.⁵

Hypercalcemia of malignancy is broadly divided into 2 categories: humoral hypercalcemia of malignancy and local osteolytic hypercalcemia. The former refers to the paraneoplastic release of humoral factors, mainly parathyroid hormone-related peptide, whereas local osteolytic hypercalcemia refers to the local destruction of bone by

tumour with calcium release. There might be considerable overlap between these 2 mechanisms in the pathogenesis of HCM.⁶

Second, "Hypercalcemia can be corrected with saline, diuretics, and bisphosphonates." Since their introduction, parenteral bisphosphonates have become the mainstay of treatment for HCM. As before, copious hydration for volume reexpansion is crucial. With respect to loop diuretics, despite their ability to promote calciuresis, they should be used with caution because of the risk of recurrent hypovolemia and metabolic abnormality.⁶ If diuretics are utilized, ensure the patient is fully hydrated and avoid thiazide diuretics, which could worsen hypercalcemia.⁷

—Gary R. Wolch MD
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by e-mail

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(July 2008)
4. **Video Series:**
Punch biopsy
(July 2008)
5. **Video Series:**
See one. Do one. Teach one.
Office-based minor surgical procedures
(June 2008)

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Good analogies, but...

Thank you for the article "Fishing and history taking" in the June issue.¹ I think a combination of—or at least an ability to equally use—both the net and the line are important, especially when dealing with those rare conditions, which occasionally present themselves, that can sometimes only be lured with a net rather than a line!

—Gurjinder S. Bhari MD
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by Rapid Responses

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Choreographing government's agenda

Iwas curious and somewhat mystified to read Dr Kenneth Kirkwood's commentary, "Casting Call,"¹ in which he adds his authoritarian voice as an academic ethicist to the chorus of government acolytes now attempting to further limit the civil liberty of physicians.

By way of explanation of the purpose and timing of his editorial, Dr Kirkwood (PhD) tells us that there has been "little evidence of debate about [the subject] in academic and professional journals." Readers should know that the College of Physicians and Surgeons of Ontario (CPSO) initiated discussion on this matter through a proposed new policy called "Establishing a Physician-Patient Relationship" a full 6 months ago.² And no less a body than the Ontario Human Rights Commission has already weighed in with its views.³ There is little doubt that, legally, physicians (like all other service providers) are prohibited from discriminating on the grounds listed under the Human Rights Code (including disability). And yet, aside from Ontario Human Rights Commission issues, physicians are still free to enter into contract with anybody, so long as both parties agree. Contrary to Kirkwood's suggestion, much heated debate is currently taking place within the profession in Ontario, and several reports regarding the same have appeared in the *Ontario Medical Review*, *The Medical Post*, and the CPSO's own *Members' Dialogue*.

The issue here is a doctor's right to freely enter into contract with his or her potential, individual patient. And, I suspect, the CPSO will soon tell us what, if any, further infringement to individual liberty it intends to impose upon the profession after its General Council meeting in the fall.