letters to the editor

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The end of compulsory retirement?

Editor – I was interested to read the latest Conversations with Charles (*Clin Med* 2009 pp 199–200). Three years ago I applied for a locum paediatric post in Edinburgh and was turned down because of my age of 71. As a member of the General Medical Council (GMC), I complained of age discrimination to them to be told they 'had no remit over the policy of the NHS including how it meets its obligations under equality legislation'. This occurred despite the fact that the GMC had twice trumpeted its opposition to discrimination on grounds of age and other criteria in its *GMC Today* (June 2006) and again with the announcement of its GMC Equality Scheme (*GMC Today* March 2007).

Neither of my letters to *GMC Today* asking whether their statements meant anything or were merely the mouthing of platitudes were published – though the editor did thank me for writing!

While I agree with Charles that performance may decline with age in the individual, I do not understand why opinions of one's competence by colleagues (including two in the UK) who worked with me are not more important than mere chronologic age. Otherwise, what is the point of having referees? Need one add good qualifications of a paediatrician in current practice, proof of many continuing professional development points, regular attendances at congresses and refresher courses and robust health?

I must presumably accept the GMC's meek statement that they cannot do anything when the NHS (probably the major employer of their members) practises age discrimination. However, why then does the GMC hypocritically publicise its so-called opposition to discrimination?

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In response

The letter was shown to Charles, who is grateful for Dr Karabus's interest and is in full agreement with him, saying 'I must confess I am not surprised. The GMC is not unique among public bodies in being inconsistent in its approach to different constituencies. It may have felt it was improper to plead on behalf of an individual. Nevertheless it is ironic that this occurred at a time when the GMC precipitately pursued an unintended consequence of the same legislation to the disadvantage of many individuals in discontinuing the fee waiver for those over 65. It could have held that in view of the serious implications for many semi-retired doctors and their clients, and the impending changes in the fee structure, the earliest practicable way to comply with the law was to await the introduction of licensing and make all the changes at the same time. By chance last month's conversation raised a similar issue where there is a conflict between the ethical advice not to allow financial gain to influence clinical decisions and inducement payments by the NHS to general practitioners. While the GMC is very willing to give strict advice to individual doctors it seems less willing to help them to carry this out by raising the issue with their commissioners and the government. If the GMC really abhors age discrimination and improper financial considerations, I believe it should not be afraid of causing upset, but be more forthcoming in letting its views be known to those who might be involved'.

Diagnosing dying in the acute hospital setting (1)

Editor – The paper by Gibbins and colleagues (*Clin Med* April 2009 pp 116–9) deals with an important subject. It shows the limitations of an approach grounded in the specialty of palliative care, which deals with death from single pathology, when analysing death on acute wards. There is no mention in their paper of dementia when those patients over 80 who die from pneumonia are often those with concomitant advanced dementia. The Liverpool Care Pathway (LCP) is less helpful in predicting dying in these patients as many of them have been bedbound for many months and have a long-term fluctuating inability to take medication and fluids. Predicting when these patients enter the terminal phase is difficult.[1,2]

In a pilot study we looked at 83 acute patients aged 75 and over to examine prediction of death in two weeks. In total, six died. Experienced consultant opinion had a positive predictive value (PPV) of 44% and a specificity (S) of 94%. Farrer's criteria, similar but more extensive than the LCP criteria, had PPV of 30% and S 91%.[3] Serum albumin less than 31 g/l had PPV 24% and S 79%. To minimise false positives any prediction method needs high positive predictive value and high specificity.

The culture of specific wards for the care of elderly people is to look for what is remediable and palliate what is not. Geriatric medicine and palliative care need to work together to find ways to make clinicians more confident in 'diagnosing dying'.

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3 Hockley J, Clark D. *Palliative care for older people in care homes*. Buckingham: Open University Press, 2002.

In response (1)

Thank you for the opportunity to respond to the letter by Kafetz and Atkin. They state that our paper 'shows the limitations of an approach grounded in the specialty of palliative care that deals with death from a single pathology, when analysing deaths on acute wards'. First and foremost, we would like to highlight the fact that palliative care does not just deal with death from a single pathology. The World Health Organization definition describes palliative care as 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems; physical, psychological and spiritual'.[1] Of note, there is no reference to diagnosis; the definition encompasses the care of patients with a spectrum of illnesses and prognoses. As clinicians working in this specialty we have daily encounters with patients with complex needs from many 'pathologies' other than cancer.

As suggested in our article, we agree the Liverpool Care Pathway (LCP) is not particularly helpful in 'diagnosing dying' for patients with many non-cancer illnesses. For example, patients with stroke and dementia may be bed bound and unable to swallow tablets, but not dying. For this reason, we used a pragmatic approach for our audit using the LCP criteria and/or case note documentation to determine whether and when a patient had been 'diagnosed as dying'. Kafetz and Atkin suggest many patients over the age of 80 dying of pneumonia have concomitant dementia; in our audit, of the 49 individuals who fell into this age category, 16 had a primary diagnosis of a chest infection and four of these had a documented diagnosis of dementia.

The authors suggest, 'The culture of specific wards for the care of elderly people is to look for what is remediable and palliate what is not'. Surely this is how medicine should be practised across all specialties and all ages, not just for the elderly? They propose that 'geriatric medicine and palliative medicine find ways to make clinicians more confident in 'diagnosing dying''. We agree, and acknowledge that the diagnosis of dying is difficult to make.[2,3] Our current research into end-of-life care on acute hospital wards suggests that a huge cultural shift is needed away from the concept of death as failure, and towards open discussions about death as a possible outcome so that it can be anticipated and planned for. We therefore still believe the key approach is 'to assist clinicians in identifying those patients who might die during their current hospital admission thereby enabling active treatment where appropriate alongside symptom relief and advanced care planning for the future'.[2]

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3 Higgs R. The diagnosis of dying. *J R Coll Physicians* 2000;33:110–2.

Diagnosing dying in the acute hospital setting (2)

Editor – Gibbins and colleagues show that providing end-of-life care is a challenge in hospitalised patients (*Clin Med* April 2009 pp 116–9). We conducted a similar audit in acute medical patients and reviewed case notes of 50 patients who died following admission to the department. We excluded patients who died within seven days of admission as we felt that the clinical uncertainty during this period would be very high. Our results are similar to the findings in the article with 62% (31/50) of patients being identified as having end-stage disease and only 54% (17/31) of them being offered end-of-life care. The Liverpool Care Pathway (LCP) was used in 13 patients. Five of these also received specialist palliative care input. Four patients had specialist palliative care input without the use of the LCP.

We agree with the authors that the uncertainty in diagnosing dying is perhaps a major contributor to patients not receiving palliative care but we feel that other factors, such as frequent transfers of patients between wards, which occurred in 27/50 patients in our audit, and reduced continuity of care owing to shorter shift patterns and frequent junior staff changes, also contribute to delay or denial of end-of-life care.

The majority of the patients in our audit were admitted with an infection and in the majority of the patients the cause of death was infection. It is often thought that infections can be treated despite the presence of other significant co-morbidities. There is little recognition among healthcare staff, patients and relatives that an infection is often the terminal event in most end-stage diseases. A number of such patients would have had previous admissions with similar infections in the past and recovered, which adds to uncertainty about diagnosing the terminal event. In our audit 15 patients had previous admissions within the last two months.

We feel that it is important to discuss with patients and relatives the role of infection as a terminal event in chronic illness, so that they are informed and not alarmed when healthcare staff decide not to treat infection actively. We also feel that the LCP should indicate that in cases of uncertainty it may be appropriate to give antibiotics despite the decision to provide end-of-life care as we feel that this will help healthcare staff to allay their own and their patients' anxieties in instances of clinical uncertainty, thereby promoting wider use of the LCP.

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