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### In response

This letter raises two important issues concerning the assessment of pain in people with communication impairments.

The first questions the validity of judging the presence and severity of pain from observed behaviours in a communication-impaired population. For some of these individuals there is no other option but to assess pain by proxy and we would entirely agree that the generic behavioural pain scales that have been developed for this purpose are neither reliable nor sensitive enough to provide more than a suggestion of the presence of pain or discomfort. Further detective work on the part of the clinical team is essential before decisions can be made about intervention.

The second concerns a patient's ability to comprehend the concept of pain sensation, as opposed to pain affect or other distress, and to use a pain tool to indicate its presence and severity. We see no reason why dysphasic patients, many of whom are already disenfranchised from engaging in discussion about their care, should not be given the opportunity to convey information about their pain, or any other subjective state, with the assistance of enhanced tools presented by trained staff, for example speech and language therapists. Many of these patients have difficulty using traditional rating scales<sup>1</sup> and we have found that creating a 'communication ramp' by using the scale of pain intensity (SPIN) alongside pictures and gestures can enable some to communicate successfully about pain,<sup>2</sup> which is empowering for both staff and patients.

Caution is, however, always needed

when interpreting information about pain, whether through self-report or by proxy, and we would agree with others<sup>3</sup> that a comprehensive pain assessment should consider both these sources as offering complementary perspectives on what is often a complex clinical picture.

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### Tuberculosis: where are we going?

Thwaites' excellent editorial detailing the latest advances in research into new drugs, vaccines and diagnostics for tuberculosis (TB) finished on an upbeat note with a call for 'unsurpassed cooperation between scientists, clinicians and politicians' (*Clin Med* November/December 2006 pp 523–5). One word seemed to be missing: money.

Current funding for all research into TB is estimated to be under \$500,000,000, approximately half of that required to fund a single drug in development from discovery to clinical use. Yet this amount has to be spread across all drug, vaccine, diagnostic and operational research. A recent report shows that the World Bank funding into TB in Africa is wholly inadequate.<sup>1</sup> In contrast funding for the World Health Organization's other priorities, HIV/Aids and malaria, is reasonable. As the editorial points out, TB is increasing at 1% a year across the globe and 5% in areas of high HIV prevalence. In the UK the increase over the last year has been 11%.<sup>2</sup>

In 2004 the Chief Medical Officer's report on TB resulted in a flurry of committee activity and well-intentioned rec-

ommendations. In 2006 the National Institute for Health and Clinical Excellence published its guidelines on the management of TB.<sup>3</sup> Despite these initiatives, evidence is accumulating that we are not even maintaining previous levels of service as funding is being reduced at a local level.

Unless the world in general and the UK government in particular wake up to the fact that we cannot bring TB under control without adequate resources the situation is going to deteriorate badly.

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### Self-harm in the general hospital

Editor – I was interested to read Kapur's article (*Clin Med* November/December 2006 pp 529–32). I would just like to take issue with the perspective which looks largely at the impact of family and society on the behaviour and outcome of the patient, but little in the opposite direction. In particular, I am interested in the impact that a parent's suicide attempt may have on their children, and more alarmingly the strong association between mothers who harm themselves and physically abuse or neglect their children.<sup>1,2</sup> I think it is of paramount importance that when a parent of young children attempts suicide, the welfare and safety of the children is taken into account. This would entail taking a complete family history, and viewing parental self-harm as a child protection crisis. It might involve, with the patient's consent, informing general practitioners, health visitors, school nurses or paediatricians. I would certainly recommend that in

all cases a referral to social services would be appropriate.

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#### A personal view of assisted dying

Over my ten years in palliative medicine the accusations levelled against morphine have been a constant feature and, with the passing years, the frequency of such accusations does not seem to change. Relatives' misperceptions are common and are perhaps understandable with comments such as: 'starting morphine, well that means the end doesn't it?'. Often patients tend to be more trusting, with an understanding driven by a need to obtain relief from their unpleasant symptoms. Colleagues often share these misperceptions: 'now that we know we can't make you better, we can start morphine' – suggesting that while you may still be cured you do not require effective pain relief. For those still in training it is a regular topic in education sessions and informal discussion. Among senior colleagues, especially those who influence policy, such gaps in knowledge are far less acceptable or understandable.

Frustration among colleagues is common. Accusations that although using opioid analgesics effectively to control pain we bring about an earlier death cause unnecessary fear for patients and families. With a need to reassure myself, and hopefully colleagues, that these accusations were misplaced I invested time in research and writing.<sup>1,2</sup> Clearly this is a difficult area to research but there is no evidence that using opioids in line with usual palliative medicine practice shortens life either in cancer or neurological disease.<sup>3,4</sup>

Two examples came to me recently that led me to write this letter. Firstly, a senior doctor writing to a relative of a patient in a hospice explaining that morphine doses would now be increased resulting in the

shortening of her life – implying this was normal practice in the hospice environment. The patient died peacefully 15 days later on the same dose of morphine.

Secondly, the recent article in *Clinical Medicine* (November/December 2006 pp 412–13). My sincerest sympathies go out to the author. Every day people go through similar battles to get good end-of-life care in acute hospitals. It is a hard task for acute units when faced with so many other demands on their time and it is genuinely challenging for the professionals involved to switch from providing acute, curative medicine to a focus on comfort and end-of-life medicine. All hospital palliative care teams work hard to try to improve this transition, and I am grateful to my local colleagues who are considerate of dying patients' needs. I am relieved that the hospice provided the last few hours of comfort – though it is a shame it was only for such a short time. But again morphine gets blamed for shortening a life with a suggestion that this is usual practice in a hospice to help the person on their way. Perhaps an alternative explanation is that this was clearly a frail lady dying from prolonged vomiting and advanced malignancy. The medication she received on her transfer purely made her more comfortable during this last phase of her life.

I have seen the blissful relief when morphine starts to work in reducing pain or breathlessness that all too often had been chronic and unrelieved. It is one of the most satisfying achievements in medicine to effectively remove a patient's pain. I know also that if morphine doses go too high the side effects can be unpleasant. In my early days as a senior house officer I increased a dying patient's morphine day after day believing her to be in pain. In fact she was agitated, not in pain, and all the morphine did was to increase this agitation, making her more uncomfortable and certainly not shortening her life. With my consultant's intervention, a low dose of the appropriate anxiolytic soon improved her agitation, ensured her comfort and the morphine dose came back down.

A huge amount can be achieved by palliative care despite the very short time periods we are often left to work in. Perhaps people (professional and non-professional)

do not realise this and we need to do more to broadcast our successes. Palliative care practice is more than just about the use of morphine, or other drugs. The skills of the team members, the approach to the patient and family, the attention to other issues than just the physical – in particular the psychosocial and spiritual – and the environment are all vital.

We cannot resolve all problems; it would be unprofessional to suggest we can. Occasionally, despite the efforts of the multidisciplinary team and the pharmacological approaches at our disposal, symptoms remain intransigent and intolerable. In these situations we can, and do, turn to sedation. This raises an ethical debate in itself and much work has examined this area.<sup>2,5</sup> But on the rare occasions when a patient meets the criteria and sedation is the only way to relieve their distress, midazolam is far more effective than morphine in making their time before death less distressing.

End-of-life care for many people could be significantly improved by changing opinion about the appropriate use of morphine. With all the discussion around assisted dying, one thing is clear: there is a need for a greater understanding of the evidence that guides practice around the end of life. If laws are to be changed then we need to start from a position of common understanding and accurate information.

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