letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Transition: provision of assistive technology can enhance independence and reduce carer strain

Editor – Jordan and McDonagh are to be congratulated on their conference report on transition (*Clin Med* September/October 2006 pp 497–500). I would particularly agree that health professionals need to look 'outside of the health box' and that 'a key principle of transition is planning'. Rehabilitation medicine specialists understand these principles and may often be the logical physician to work with paediatric services during transition and to support these young people through the many changes that occur throughout adult life.

The conference report made no mention of the role of assistive technology in helping these young people and their families. For those with severe physical disabilities, these challenges become acute during the teenage years, either because of the effects of growth, creating increasing difficulties with transfers and mobility for those with static disability, eg cerebral palsy, or the aggravation of growth effects on a deteriorating condition, eg muscular dystrophy.

The value of an environmental control unit (ECU) demonstrates the role of planning for such an individual. Thus a child with Duchenne muscular dystrophy may be introduced to an ECU early when they are unable to access the television set, later they can use the ability to control lights in the bedroom to minimise disturbing their parents, and later still they can control the doors giving access and exit from the home – with the parents safe in the knowledge that they can be contacted if needed.[1] It is postulated that decreasing the physical strain on parents may also facilitate the emotional separation that naturally occurs in most able-bodied youngsters as they mature.

Such an individual requires outdoor independence and since 1996, the NHS has provided electric powered indoor/outdoor wheelchairs (EPIOCs) for those with severe disability and who fulfil stringent criteria.[2] The quality of life of young people (aged 10–18 years) given an EPIOC has recently been evaluated.[3] As an 18-year-old with spina bifida stated, 'I can do everything myself. It's been fabulous. It's been great to have it.'[3] The mother of an 18-year-old with cerebral palsy described the benefits of an EPIOC:

> *It enables him to go out with his friends. It is helpful. He feels good. He can go out. He's not dependent. He likes to use it all the time. He's not dependent on somebody pushing him. Because he feels good, then I feel good also.*[3]

Another mother (of a 17-year-old with muscular dystrophy) stated, 'It gives me more independence.'[3]

Evans *et al*[3] give added support to the view that EPIOCs reduce carer strain[2] and so we have the situation that assistive technology not only enhances the lives of young people but also reduces the strain on their parents – two objectives that must be met if young people are to take their place in society as they mature.

ANDREW FRANK
Consultant Physician in Rehabilitation Medicine and Rheumatology, North West London Hospitals NHS Trust

References

1 Paul S, Frank AO, Hanspal RS, Groves R. Exploring environmental control unit use in the age group 10–20 years. *Int J Ther Rehabil* 2006;13:511–6.
2 Frank AO, Ward JH, Orwell NJ, McCullagh C, Belcher M. Introduction of the new NHS electric powered indoor/outdoor chair (EPIOC) service: benefits, risks and implications for prescribers. *Clin Rehabil* 2000;14:665–73.
3 Evans S, Neophytou C, De Souza LH, Frank AO. Young people's experiences using electric powered indoor-outdoor wheelchairs (EPIOCs): potential for enhancing users' development? *Disabil Rehabil*, in press.

In response

The multidimensional and multidisciplinary nature and remit of transitional care is broad and far reaching as the letter in response to our article exemplifies. It is impossible to be totally inclusive given the word limit of articles and hence ongoing discussion and research is to be welcomed. This year's national transition conference 'From talk to action', sponsored by the Department of Health, was held on the 12 March 2007 at the Royal College of Physicians in London. The conference included a particular emphasis on the adult provider perspective of transition and the challenges faced by paediatric teams when there is no equivalent adult team available including neurodisability and some areas of child mental health. Further details can be obtained from info@camhs.biz

ALISON JORDAN, JANET E MCDONAGH
Birmingham Children's Hospital

The Mental Capacity Act 2007

Editor – The Mental Capacity Act 2005 comes into full legal force in April 2007. I conducted a brief survey (n=32) of hospital physicians via a questionnaire. This showed that only 50% had heard of the Mental Capacity Act 2005 and only 6% knew when it was being implemented.

There were important misunderstandings in assessing capacity: 56% thought active schizophrenia meant the person was by definition incapable; 16% thought Alzheimer's disease meant the person was by definition incapable; 16% thought

severe depression meant the person was by definition incapable; 38% thought that a recent assessment of incapacity meant the person was by definition incapable, but this is wrong as a capacity assessment is only valid for a specific question at a specific point in time. No completed questionnaire had all the answers correct.

With the full implementation of the Mental Capacity Act 2005 fast approaching this shows a great need for teaching and guidance on capacity.

CHRIS SCHOFIELD
Specialist Registrar Liaison Psychiatry
Queens Medical Centre, Nottingham

Napoleon's doctors

Editor – I read the book review on *Napoleon's Doctors* with interest. I imagine that members of my Society would be happy to claim the victory at Waterloo for Admiral Lord Nelson and although he had been dead for 10 years, perhaps his influence came from above. The two great men, Nelson and Wellington, met only once, fleetingly, at the Colonial Office on 12 September 1805. Thirty years later, by now Prime Minister, Wellington said 'I don't know that I ever had a conversation that interested me more'.

JK WOOD
Vice Chairman
The Nelson Society

While grateful for the suggestion of divine intervention it was more likely a failure on the part of the Editor to spot this error. Napoleon was of course defeated at Waterloo by the Duke of Wellington (and not by Nelson who died in 1805, ten years before the battle).

Editor

Myths of ageing

Editor – Mulley's lecture (*Clin Med* January/February 2007 pp 68–72) is very thought-provoking and raises a number of important issues concerning the negative stereotyping of older people. There is, however, another type of false reasoning about the elderly which is widespread, namely the notion that it is unnecessary to even consider a patient's age when making decisions about their treatment: some older people (and their relatives) are hopelessly unrealistic about the likely benefits of treatment, especially advanced, technologically intensive treatment, in people of advanced age. I recently had a conversation with the next of kin of a patient who was in his mid-80s. He had chronic renal failure and aortic stenosis and was not responding to treatment for pneumonia. Despite the patient's history and poor clinical condition I found it very difficult to persuade the relative that continuation of active treatment was unlikely to be of benefit.

Whether we like it or not, advancing age is a proxy for progressive loss of functional reserve in vital organs, and usually in several organs rather than just one. If one adds to this the stress of an acute illness (pneumonia, myocardial infarction or whatever) then it is no surprise if things do not go well. The able physician, it seems to me, is the one who can give proper weight to the patient's age in the overall assessment of their condition and medical prognosis. Mulley has, rightly, reminded us of the serious dangers of jumping to negative conclusions when looking after older people. I would venture to ask him also to be aware of the risk of exposing doctors to criticism (especially from patients' families) for simply attempting to make a balanced judgement about the care of older patients.

ROGER A FISKEN
Consultant Physician
Friarage Hospital, Northallerton

Modern management of atrial fibrillation

Editor – The reluctance to anticoagulate elderly patients with atrial fibrillation (AF) (*Clin Med* January/February 2007 pp 28–34), even in the absence of contraindications,[1] might, at least in part, be attributable to the fear that, in the event of treatment-related haemorrhagic complications, those patients might, by virtue of age alone, be denied life-saving interventional treatment. Already, it is acknowledged that as many as 46–48% of doctors, ranging from primary care to secondary care, would be prepared to deny patients aged >65 treatment that they would otherwise offer to their younger counterparts.[2] These attitudes are exemplified by the proposal (unsupported by any prospective study) that, following traumatic intracranial haematoma (typically a subdural haematoma resulting from 'a tumble downstairs'[3]) 'there is little point in active treatment over the age of 65 for those who remain in coma (Glasgow coma scale of 8 or less) for more than 6 h…'.[3] Furthermore, patients aged 65 or more with either extradural or acute subdural haematoma are less likely to be transferred to neurosurgical care than their younger counterparts.[4] With regard to upper gastrointestinal haemorrhage, although an audit of patients with bleeding peptic ulcer documented a reduction in mortality if the over 60s were operated on early,[5] this does not necessarily translate into a more proactively interventional stance for the over 65s and over 75s with this complication, given the recent findings on doctors' ageist attitudes.[2] In the final analysis, it is our uncertainty about the attitudes of our colleagues which generates a reluctance to prescribe anticoagulants to the over 65s.

OMP JOLOBE
Retired Geriatrician
Didsbury, Manchester

References

1 Friberg L, Hammar N, Ringh M, Petterson H, Rosenqvist M. Stroke prophylaxis in atrial fibrillation: who gets it and who does not? *Eur Heart J* 2006:27:1954–64.
2 Harries C, Forrest D, Harvey N, McClelland A, Bowling A. Which doctors are influenced by a patient's age? A multimethod study of angina treatment in general practice, cardiology, and gerontology. *Qual Saf Health Care* 2007:16:23–7.
3 Maurice-Williams RS. Head injuries in the elderly. *Br J Neurosurg* 1999:13:5–8.
4 Munro PT, Smith RD, Parke TR. Effect of patients' age on management of acute intracranial haematoma: a prospective national study. BMJ 2002:325:1001–3.
5 Wheatley KE, Snyman JH, Brearley S *et al.* Mortality in patients with bleeding ulcer when those aged 60 or over are operated on early. BMJ 1990:301:272.

In response

It is with interest that we read comments raising the possibility that the ageist attitudes of physicians is the primary factor responsible for the under-prescribing of anticoagulation in those at greatest risk of