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 email to: Clinicalmedicine@rcplondon.ac.uk

Antituberculosis drug resistance

Editor – Chapman's excellent editorial on tuberculosis (TB) drug resistance is a salutary reminder that this is likely to be an increasing problem (*Clin Med* October 2008 pp 478–9). It does, however, beg the question as to how a clinician is to manage such cases. The problem with drug resistant TB is that it is still relatively uncommon. Individual clinicians will therefore have little experience in managing cases. To help this situation, the Multi-Drug Resistant Tuberculosis (MDR-TB) Service has been established at the Cardiothoracic Centre in Liverpool and has been operational since 1 January 2008. The service has the support of the relevant professional bodies, including the British Infection Society, the Department of Health and the Health Protection Agency. Funding for this service has been provided by an unrestricted educational grant from Genus Pharmaceuticals. Essentially it is an electronically linked instant reaction expert group, which includes chest physicians, infectious disease physicians, paediatricians, public health specialists and microbiologists, who can give advice and direct management of cases across the country. It has already done so in some 26 cases from across the UK. By helping clinicians in the management of cases of drug resistant TB this national service offers our best hope in overcoming the increasing problem of drug resistance until new drugs become available. The Baltic states have operated a similar system for some years with good success in reducing their cases. The second function of the service is to collect data on all cases of multidrug resistant TB identified in the UK, with a view to developing a consensus on the most effective methods of treatment in this emerging area. The data collection will also help assess patient outcomes. The service can be contacted by email (MDRTBservice@lhch.nhs.uk) or by phone (0151 600 1427).

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A life in the day of Mrs W

Editor – David Kerr's paper captures perfectly the experience of many patients in the modern health service (*Clin Med* October 2008 pp 515–6). It is reminiscent of the recent Romanian film *The Death of Mr Lazarescu* in which a dying patient is kept on a trolley overnight and shunted around several different anonymous hospitals. The huge concern is that our focus has been taken off the obvious – patient care. Commonsense has increasingly been pushed aside in our protocol-driven, production line approach to hospital treatment in the 21st century.

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Following the publication of 'A life in the day of Mrs W' the Editorial Office received the following letter from a member of the Patient and Carer Network who has experience as a national charity chief executive.

I have recently been involved as a relative during the last three months of the life of my 91-year-old mother. She had a stroke some five years ago followed by a vascular dementia and had been in a care home for two years. In March 2008 she sustained a fractured hip requiring two operations with multiple complications including pneumonia, myocardial infarction and *Clostridium difficile*. She developed renal failure, bed sores and couldn't eat or drink. It was agonising to watch someone you love suffer in such pain and distress

My reason for writing this letter is to highlight two issues. I have no complaints about her nursing care but what I do find difficult to understand is the lack of communication with the medical staff looking after her. On no occasion did I or my sister receive any information without first arranging an appointment. We did this on two occasions but with different consultants at different stages of her illness. Surely communication with relatives should be of paramount importance when a person is at the end of their life? One needs to know the situation, what can and can't be done. Just a little time and consideration can mean a great deal but it seems that no time is allocated for this important function. I live a distance away and was visiting about three times a week, therefore it was important to me to find out as much as I could.

Towards the end I asked for an appointment to see the consultant to discuss the situation. He was very understanding. My main concern was why were they still treating my mother when the end was near and she was asking to die? He explained that they were prolonging the inevitable. My sister and I both agreed that we just wanted Mum to be pain free and have a dignified death. He agreed and a Macmillan nurse came to look after her. She was put on a morphine pump with no other medication other than for her diabetes and any plan to force feed her was abandoned.

She died quietly three days later. I know that each consultant has a large case load, but I do feel that relatives should be involved in any decisions of this nature but how can they without close communication with the medical team? There should be dignity in death with each person being treated individually. A treatment plan could have been made much earlier if someone had listened to us. Mum and her next of kin could have avoided so much pain and distress.

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The significance of early HIV testing (1)

Menezes *et al* present a salutary lesson of the month regarding the consideration of early HIV testing (*Clin Med* October 2008