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

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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References

1 Murray SA, Kendall M, Boyd K *et al.* Illness trajectories and palliative care. *BMJ* 2005;330:1007–11.