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Editor's choice

The problem with the Liverpool Care Pathway is that someone felt the need to give it a name. Once it had a name it also developed boxes that needed ticking. Everything really went downhill from there. In nearly 30 years of general practice I've looked after many dying patients, but each individual's needs are different. Perhaps it's because I haven't given what I do a name, that I haven't stopped doing it and am going to continue until I retire, working in the same way. Of course, because there are no boxes, there are no QOF points to it; but, I'm rather pleased about that.

JA Glasspool,

*Victor Street Surgery, Victor Street,
Shirley, Southampton, SO15 5SY.*

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Proceed with caution

Beales and Tulloch's arguments about anticipatory care of older patients¹ represent the triumph of hope over experience. Anticipatory care for older people in the community has not yet been shown to be clinically or cost-effective in a thorough and less selective overview of the literature.² Trials of anticipatory care for older people in US, UK, and Denmark up to 1990 showed a rise in patients' morale, increased referrals to all agencies, reduced duration of in-patient stay (sometimes), increased in-patient rates (mostly respite care), reduction in mortality in some trials, but no improvement in functional ability and an increase in GP workload unless alternative services were provided.³

Evidence for the benefits of anticipatory care remains scarce. The UK MRC trial showed little or no benefits for quality of life or health outcomes for older people receiving comprehensive assessment.⁴ A systematic review of 15 trials of preventive home visits for older people showed no clear evidence of benefit⁵ while the ProAge trial

yielded no change in health-risk behaviours in older people.⁶ Case management has not reduced hospital admission rates for frail older people and may even cause disruption of established nursing teams and services.

There are signs that effective interventions are being developed but effect sizes in positive trials are often small and may not remain when interventions are transferred to routine practice. GPs should be cautious about committing time and resources to forms of anticipatory care for older patients that are plausible but untested.

Steve Iliffe,

*Professor of Primary Care for Older
People, University College London.*

E-mail: s.iliffe@ucl.ac.uk

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The right to die peacefully

The editorial¹ and accompanying article² in the October edition of the *BJGP* highlighted the problems of advance care planning in older people. We detail below the tragic consequences of failure to have these conversations.

A review of case notes of patients registered with a local CCG, who were over 75 years of age and died after spending no more than 1 night in hospital between 1 January 2013 and 31 March 2013, showed that there were 31 such deaths. Of these, eight came from nursing or residential homes and five of these patients were recorded as being unresponsive or had a GCS of 3 when first seen by the ambulance crew. At least six of the patients would have met the Gold Standards Framework prognostic indicators criteria for being on the palliative care register, and in two the family requested admission or resuscitation in case of collapse.

At least four of these cases were pre-alerted to hospital and taken directly into the resuscitation area for multiple investigations and treatments: frail older patients, clearly nearing the end of life, precipitated into hospital where staff feel an obligation to try to preserve life. Most of these patients do not have the mental capacity to understand what is going on around them, and probably find the interventions extremely distressing. The whole process serves only to cause unnecessary suffering.

In some cases the family were not prepared for the patient's demise, and in most the care institutions were not confident in the management of patients nearing the end of life. The ambulance services are put under considerable pressure and without clarity from the carers will understandably default to an active resuscitation mode.

It is a challenge to primary care to champion the rights of older people to die peacefully.

Chris Gunstone,

E-mail: chris.gunstone@nhs.net

Liz Waddy,

*GP and Clinical Lead for End of Life Care
East Staffordshire CCG.*

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Response to 'Do the elderly have a voice'

We read with interest your review of advance care planning decisions with frail and older individuals.¹ As two geriatric registrar trainees we have found a spectrum of good and bad practice in hospital and variation in the opinions of patients and families towards advance care planning.

It can be easier to initiate conversations about future care when the elderly have been admitted acutely, which often focuses thoughts on mortality. However, they themselves are often too unwell to participate in such conversations, or they may make a different decision than if asked when they had been stable and in their own home.²

Within geriatrics there has been an increasing interest in advance care planning coupled with more geriatricians working in the community. We are well placed to initiate conversations about advance care planning but equally it may also be done by GPs with a long-term relationship with the patients. A collaborative approach with improved communication across sectors may be the way forward.

We recently conducted an audit into admissions from nursing homes and found our communication on discharge of DNACPR decisions and advance care planning done in hospital was extremely poor: only 24% of decisions were documented on the initial discharge letter to GPs. However we did find that when advance care planning was done and communicated on discharge it was largely successful in ensuring that the preferred place of care was met.

This is a difficult and highly emotive area which needs more time and development but has the potential to improve the quality of life for older patients.

Anna Folwell,

ST5 in Geriatric Medicine, York Hospital NHS Trust, Wigginton Road, York.

E-mail: annafolwell@gmail.com

Danielle Ronan,

ST5 in Geriatric Medicine York Hospital NHS Trust, York.

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An additional cause of prescribing error

I would like to add another category of error to the helpful description given by Slight and colleagues.¹

A patient of mine was approached to take part in a trial of medication: the REVEAL study (<http://www.ctsu.ox.ac.uk/~reveal/>). This seeks to test a new drug, anacetrapib, in the context of lipid lowering. The paperwork was scanned into our EMIS Web system and I reviewed the letter. The EMIS prescribing module allows 'red' drugs to be included in the prescribing record so that possible interactions with proposed new medication is highlighted.

Unfortunately anacetrapib is not included in the drop down menu and so I contacted the study organisers. There is no requirement for medication being tested in a clinical trial to be available in GP systems for addition to the prescription screen. I can foresee circumstances when interacting medication could be added un-knowingly by myself or colleagues. This gap in the system needs to be addressed and I have contacted the National Research Ethics Service for guidance.

Pawan Randev,

GP, Measham Medical Unit, High Street, Measham, DE12 7HR

E-mail: pawan.randev@nhs.net

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Out-of-hours care

I provide 41 hours per month to our local

service. I agree that the work is different to our daytime work but many skills are interchangeable. Daytime work does not involve the frequency or intensity of managing urgent primary care problems. It seems to me that many of my colleagues are becoming less confident and de-skilled at this work, to the point that it is becoming almost a sub-speciality of general practice.

Mick Leach,

Dr Moss & Partners, Harrogate, HG1 5JP.

E-mail: Mick.Leach@gp-b82013.nhs.uk

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Non-directed altruistic kidney donation

Neuberger and Keogh's editorial on organ donation makes a very brief reference to altruistic kidney donation.¹ When a mechanism to support the process was established in 2006 it was anticipated that there would perhaps be 10 or so such operations per year. This was the case initially but word has got around, principally as a result of media stories, and numbers have increased with 76 altruistic donations in 2012/2013.²

We do not know the size of the pool of people willing to donate in this way but surveys in several countries including the UK have shown that a substantial proportion are willing to consider giving a kidney to a stranger.³ In the UK there is a clear and well-planned assessment pathway in place in transplant units. Publicity has increased awareness which has led to more volunteers. NHS staff involved in transplantation have become increasingly confident that altruistic donors are generally ordinary, healthy people with no excess of psychological morbidity. They come from diverse backgrounds and include a number of doctors and nurses.

GPs may be approached by individuals interested in the possibility of donating. They don't need to know the intricacies of the cross-matching process but they can assure them that the risks associated with nephrectomy, although not trivial, are still small with a mortality of less than 1 in 3000 and there is evidence that donors have a higher than average life expectancy.⁴

There are numerous resources on the web including a charity called Give A Kidney (www.giveakidney.org) established by