

Letters

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Real life ethics

We were very interested to read the case report in the April¹ issue of the journal. It highlights the importance of patient autonomy and of allowing patients to make their own decisions regarding future care. What is concerning in the case described is that the patient's specific wishes were not followed. The patient had explicitly stated she did not wish to be hospitalised and wanted nature to take its course. However, when the patient was very unwell and became unconscious, the decision was made by the GP to hospitalise the patient (albeit not the hospital she had stated that she did not wish to be admitted to) 25 miles away from her home.

Surely, the patient could have been managed differently — was it not possible to obtain rectal diazepam from a pharmacy? Also would it not have been possible to liaise with the local palliative care and district nursing teams to arrange for a syringe driver to be set up at home to allow the patient to be managed in her place of choice? Palliative care is about forward planning and decision making. Spending a night in A&E, followed by a week on a general ward does not usually afford good palliative care and in this case the response of the GP made a mockery of this patient's desire to have some control over the last days of her life.

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REFERENCE

1. Brown E, Pink J. Real life ethics: autonomy versus duty of care. *Br J Gen Pract* 2008; **58**(549): 288–289.

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Author's response

Professor Lloyd-Williams and Dr Reeve clearly share our commitment to respecting patient autonomy in health care. It is because of this commitment that we highlighted practical barriers that can arise during emergency care within a complex multi-agency system governed by a variety of rules and procedures that are often not compatible. We can probably all agree too that services should be developed in a way that takes account of such problems.

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Preoperative anaemia

Blood transfusion may be beneficial and life saving in particular clinical situations. However, transfusions do carry some risks. Blood is a limited resource and liable to shortage at times of peak demand. Total hip replacement surgery accounts for 4.6% of blood used in hospitals and studies have shown a wide variation in transfusion practice for this procedure. A pre-operative haemoglobin (Hb) of less than 12 g/dl increases the likelihood of transfusion threefold.

NHS Blood and Transplant, in

collaboration with the Royal College of Physicians, carry out a series of 'national comparative audits' on transfusion practice, acknowledged by the Healthcare Commission. These audits evaluate safety of transfusion and appropriateness of blood usage. The aim of this prospective audit was to measure transfusion practice in 'primary total hip replacement' surgery (THR) against two performance indicators and four practice standards. The audit report highlighted deficiencies in practice nationally and made recommendations to improve transfusion practice.

Two hundred and twenty-three hospitals submitted data for 7465 patients who underwent THR. Nationally, 25% of patients were transfused and the transfusion rate among hospitals varied from 0 to 100%. The audit found that, nationally, 29% of patients did not have a Hb estimation pre-operatively, and 15% went for surgery with a Hb less than 12 g/dl. To minimise the likelihood of patients receiving blood transfusions, preoperative anaemia should be corrected as far as possible. Hospitals should have a written policy for identification and management of anaemia in pre-assessment clinics. Surgeons seeing patients at initial consultation must ensure that patients have a full blood count, and that patients with anaemia are investigated and steps are taken to correct the anaemia before surgery. GPs referring patients for surgery should take measures to optimise the haemoglobin.

Studies have shown that previously undiagnosed anaemia is identified in more than 30% of patients undergoing elective surgery and a third of these are due to iron deficiency. This anaemia in the absence of chronic blood loss responds well to oral iron. It takes several weeks to optimise the haemoglobin and there may not be