

terms of staff time saved are unquantifiable, as are longer-term savings made to the NHS from prompt diagnosis of urinary tract infection. Subsequent published papers have also shown that there is no significant difference in urine collected by clean catch versus UCP.<sup>8,9</sup>

The cost of obtaining a urine sample in babies can be considerable, not only in monetary terms, but also in time, quality of sample, delay in making a diagnosis, and discomfort for the child and family.<sup>5,6,8</sup> Clean catch samples of urine require significant input, both in time and persistence from parents and staff, and contamination is not uncommon.<sup>8</sup> Pads, however, can be appropriately sited, checked every 10 to 20 minutes, are comfortable for the baby, and parent compliance is improved.

Urinary collection pads are now widely used in the United Kingdom and will soon be available in procedure packs, comprising two pads, syringe, universal container, and instruction sheet. They are suitable for use in collecting urine from severely handicapped children, and may also be used to collect urine from elderly and confused incontinent patients.<sup>7</sup>

In conclusion, pads are a simple and accurate way of collecting urine in babies.

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## Community hospitals

Sir,

The editorial by Ritchie and Robinson (*March Journal*)<sup>1</sup> highlights the pivotal role of community hospitals in providing care throughout the UK.

These hospitals provide a high quality of care, and are usually situated near patients' homes. The use of community hospital beds appears to be increasing, with several hospitals setting up their own palliative care suite or room.

An evaluation of 72 consecutive patients cared for in one such palliative care unit<sup>2</sup> revealed that the majority were admitted for terminal care, with only a small number ( $n = 6$ ) admitted for procedures; e.g. treatment of hypercalcaemia. The majority of admissions were short term (85%) and were for less than 21 days.

Nearing the time of death, 68% of patients were commenced on a syringe driver containing diamorphine, and, in 85% of cases, one other drug was used; these were mostly antiemetics. Very few drugs were written up on the 'as required' chart, and, in the last 12 hours of life, 23 patients required medication (mostly analgesics and sedatives). As there was no doctor on sight, there was considerable delay at times in obtaining permission for medication to be given.

Possibly the use of drug charts with pre-written 'as required' drugs that the admitting doctor could complete with an appropriate dose range, may be a solution. This system is used in many hospices where there are no resident medical staff.

The principles of palliative care are applicable to all patients with end-stage disease, and the use of community hospital beds in this way may further enhance palliative care services and make such care accessible to more patients.

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## Telling the truth

Sir,

Vassilas and Donaldson (*March Journal*)<sup>1</sup> highlight the dilemma that doctors face in deciding whether to disclose the diagnosis of Alzheimer's disease, and dementia in general, to patients. They found that GPs were reluctant to tell patients that they had a dementia, and that the most important factors influencing their decision were the degree of certainty of diagnosis, the patient's wish to be told, and the patient's emotional stability. In contrast, they found that the large majority of GPs would tell patients of a diagnosis of terminal cancer.

In the early 1960s, doctors were also reluctant to disclose the diagnosis of cancer to patients, and the reasons for this practice mirror many of the reasons currently given for not telling the patient with dementia his or her diagnosis — the lack of effective treatment for many cancers at the time, and a fear of the patient becoming depressed. By the late 1970s, doctors' practices with cancer patients had changed dramatically,<sup>2</sup> partly due to improved treatments and also a growing belief that the patient had the right to know.

However, we feel that Vassilas and Donaldson omitted to discuss what is possibly the greatest barrier to disclosure of diagnosis to the patient with dementia — the resistance of family members. In 1996, from a memory clinic in Dublin, we published a study of family members' attitudes toward telling patients with Alzheimer's disease their diagnosis.<sup>3</sup> In 83 out of 100 cases the family member said that their relative should not be told the diagnosis. The main reason given was a fear that the disclosure of the diagnosis would upset or depress the patient. In contrast, 71 of the 100 relatives wished to be told the diagnosis should they themselves develop Alzheimer's disease, emphasizing their 'right to know'. This dramatic inconsistency may be puzzling, but is probably partly explicable in terms of a paternalistic desire to protect the (usually) older relative from distress, which, to an extent, reflects ageist attitudes ('I would be able to deal with the diagnosis, but my mother wouldn't').

The recent advent of potential treatments for Alzheimer's disease (cholinesterase inhibitors, such as donepezil) and the increasing public awareness of the disease and other dementias, may help to overcome some of the fears of both families and doctors, and herald a move towards informing the patient with dementia of the diagnosis, as happened for cancer patients 20 years ago.