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# A note for the examination board

It's that time of year again. If the hay fever has begun, the season of examinations cannot be far behind. And that means that it will soon be time for an urgent doctor's letter to the exam board to plead for special circumstances to be taken into consideration, for more time to submit a dissertation, for permission to resit the exam or repeat the course.

The expansion of the university sector appears to have resulted in the recruitment of vast numbers of students who lack either the motivation or the aptitude for academic work. This means that when exam time comes around, many, pursuing the familiar culture of 'throwing a sickie' from the world of work, take refuge in the sick role — or at least seek the respite afforded by the sick note.

I hear from friends and relations who work in higher education that no exam board now takes place without due consideration of a pile of letters from GPs supporting student appeals. The interpretation of the subtly graded degrees of enthusiasm in doctors' support for their patients' appeals has become a highly regarded skill in the senior common room. Students soon learn the importance of ensuring that their doctors' letters include objective disease labels rather than reports of subjective perceptions of illness, (if only they devoted the same energy to their courses!). The result is an annual inflation in the rhetoric of incapacity.

The pursuit of the fetish of assessment at every level of the education system has encouraged a burgeoning demand for medical certification of absence or poor performance from students in further education colleges and schools as well as universities. It will not be long before GPs are being asked to write letters to explain or excuse unsatisfactory results in primary schools SATs and pre-school assessments.

It is ironic that, at a time when GPs' role in certifying sickness in relation to employment or disability benefits has been devalued and restricted, we are expected to take on a wider role in policing the education system. We also seem to have acquired ever-expanding responsibilities in relation to leisure activities and insurance claims. Before people go on holiday they need a 'complete checkup', a certificate that they are fit to travel, a list of required medications, and a note indicating that they need a wheelchair in the airport and oxygen in the plane. When plans fall through, they need another note explaining medical grounds for cancellation.

Worship at the gym may have become the secular alternative to going to church, but attendance still requires medical approval. This too necessitates a 'complete checkup' and a declaration that physical exercise is not medically contraindicated. When enthusiasm wanes, another note may be required to reclaim registration expenses. Every minor car or playground accident, sports injury or pavement trip, pub brawl or street scuffle requires a detailed medical report, irrespective of the fact that no medical treatment may have been necessary. Patients often come to the surgery some time after incidents of this sort, not because they have injuries that need treatment, but because they have been advised that they should seek the authoritative and documented confirmation of a doctor that this incident took place (even if the doctor has no evidence other than the patient's account).

The diverse forms of appeal for medical certification reflect the breakdown in relations of trust and loss of authority in society. Lecturers cannot rely on their students, teachers do not believe what their pupils, or their pupils' parents, tell them; employers do not trust workers, service providers and service users are at one another's mercy. While politicians and health policy gurus disparage doctors for being paternalistic, others in authority are keen to take advantage of the residual legitimacy of the medical profession to compensate for their own loss of respect. The result is what Michael Power describes as 'an inflationary spiral' of mistrust.[1]

## REFERENCE

1. Power, M. *The Audit Society: rituals of verification*. Oxford: Oxford University Press, 1997.

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# Top Tips in 2 minutes

*'Wanne mine eyhen misten*
*and mine heren sissen*
*and mi most koldet*
*and my tunge ffoldet*
*and mi rude slaket ...'*

(*'When my eye mists and my hearing fails and my nose goes cold and my tongue curls back and my face falls in'*… ).[1] Identification of impending death was important to medieval man. The sacrament of extreme unction had to be administered by the priest to ensure passage into purgatory, but recovery after mistaken administration condemned the patient to a penitential life, free from meat and sex (not surprisingly, the sick often delayed sending for the priest).

What we expect from the end of our lives, is a window into the world of how we view our lives. Beowulf, son of Ecgtheow, Lord of the Geats, slaughterer of the Dragon Grinwald[2] uses his dying moments to lament that he does not have a son (a lament surely as old as time):

*'Now is the time when I would have wanted*
*to bestow this armour on my own son'*

Though other aspects of his life were different:

*'Because of my right ways, the Ruler of mankind*
*need never blame me when the breath leaves my body*
*for murder of kinsmen.'*

Perhaps the most interesting thing about our top tip on 'End-of-life emergencies' is how hard it was to find a good resource for the patient on dying. Given the fact that death, like birth is an inevitable and universal experience, what does that say about us?

**Ruth Bastable, Sarah Rann and Vinny Barker**

## REFERENCES

1. Jupp PC, Gittings C. *Death in England: an illustrated history*. Manchester: Manchester University Press, 1999.
2. Heaney S. *Beowulf*. London: Faber & Faber, 1999.

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## Top Tips in 2 minutes: Emergencies at the end of life.

**Why:**

Anticipating and planning management of possible symptoms and/or emergencies is essential in maintaining patients at home at the end of life.
Frequency of symptoms in the last 48 hours:[1]

- Noisy and/or moist breathing, 56%
- Urinary dysfunction, 53%
- Restlessness and/or agitation, 42%
- Pain, 51%
- Dyspnoea, 22%
- Nausea and/or vomiting, 14%

Consider also those related to a specific diagnosis, for example, fits, risk of haemorrhage.

**How:**

Use of syringe driver for crises, not just in the last 48 hours
The Liverpool Care Pathway for the Dying Patient[2] gives a framework for planning care at this stage and advocates anticipatory prescribing, 'Just in Case Bag/Box'.
Although reversible causes for specific symptoms should be considered, most emergencies in the last 48 hours are irreversible and the focus is relief of distress.

**What next and when:**

Treatments to consider for specific symptoms:

**Excess bronchial secretions:**

- Explanation;
- Repositioning;
- Medication: Glycopyrronium 200 to 400 mcg subcutaneous (sc) as required 6 hourly or 1.2–2.4 mg/24 hour via continuous sc infusion (csci) or hyoscine butylbromide 20 mg sc as required 6 hourly or 60 to 120 mg/24 hour csci.

**Breathlessness:**

- General supportive measures including fan;
- Diamorphine sc bolus or via csci over 24 hours (dose depending on previous opioid use) and/or midazolam sc bolus or via csci over 24 hours.

**Pain:**

- If unable to take regular oral analgesia convert to equivalent dose of sc opioid; for example, diamorphine via csci;
- Have sc diamorphine or alternative available for breakthrough pain. Consider midazolam for anxiety or muscle spasm.

**Terminal agitation:**

- Identify and treat any reversible causes, for example, drugs, pain, hypoxia, urinary retention;
- Medication: midazolam 2.5–5 mg up to 2 hourly sc can be given to assess response. Large doses of midazolam may be needed via csci (30–160 mg/24hour). Levomepromazine 25 mg stat sc, up to 4 hourly or 50 mg to 150 mg/24 hour via csci may be needed. Titrate individually, seek advice if needed.

**Fits:**

- Increased risk if no longer able to take oral anticonvulsants. Midazolam (10–60 mg/24 hour) via csci should prevent;
- Sc or buccal midazolam (5–10 mg) or per rectum diazepam (10 mg) used if fits occur. Can repeat.

**Haemorrhage:**

- Consider discussing in advance: issues of resuscitation and/or use of sedation;
- Have dark towels available;
- Catastrophic bleed causes almost immediate death with no time for treatment — stay with patient;
- Severe bleeding lasting minutes to hours is frightening, have sedation available — midazolam iv/buccal 5 mg repeated as necessary. At home rectal diazepam 10 mg is alternative.

**Patient information:**

End of life: The Facts.
http://www.mariecurie.org.uk/aboutus/helpandinformation/publications_and_resources/end_of_life

**References/Web links:**

[1]Lichter I, Hunt E. The last 48 hours of life. *J Palliat Care* 1990; **6(4):** 7–15.
[2]Liverpool Care Pathway (includes patient information) http://www.mcpcil.org.uk/liverpool_care_pathway
See also: Gold Standards Framework http://www.goldstandardsframework.nhs.uk
NLH End of Life Care http://www.library.nhs.uk/healthmanagement/ViewResource.aspx?resID=235932
More top tips can be found at http://www.addenbrookes-pgmc.org.uk/handouts.asp?title=Primary%20Care%3E

**Who are you:**

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Angela Steele, GPwSI and Macmillan GP facilitator, Cambridge

**Date:**

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Correction: Our top tip for May 2008 on the evidence-based management of osteoarthritis in the knee includes a recommendation for giving patients glucosamine. Latest NICE guidance (February 2008): http://www.nice.org.uk/nicemedia/pdf/CG59NICEguideline.pdf