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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.

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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.

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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.

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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

medical professionals and donors in 2011 to support altruistic donation. The website has contact details for the living donor transplant coordinators for those who wish to take matters further.

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CSA pass rates

We all know the figures published by the RCGP showing differences in male versus female, white versus BME, and UK graduates versus IMGs. However, I have suspected for years that the male/female difference is due to the male inability (relatively speaking), to process several possible outcomes, as opposed to jumping to the most likely and then re-evaluating, is at the centre of this issue. The possible solution to this is teaching exam technique.

I have always been puzzled by the IMG issue, as apparently has everyone else, with suggestions of bias and worse being made; similar differences also occur at AKT.

I suggest a seemingly ludicrous idea, that the difference occurs because of the fact that the data are published.

Malcolm Gladwell's book *Blink* includes the already accepted idea of 'priming'. In brief, the fact that IMG candidates are told (repeatedly and unavoidably) that they have much less chance of success primes them to fail

As an example, the standardised test for US College entrance was given to two groups of applicants. Pre-test priming by including their race on a pre-test questionnaire reduced the scores of, in this case, the African-American candidates by up to 50%. Asked afterwards none of them agreed that the pre-test questionnaire had ANY effect.

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Sustainability, carbon footprints, and dyspepsia

Roger Tisi[1] rightly draws attention to the unnecessary work that GPs have to do with little evidence for benefit. Peter Perkins[2] letter on dyspepsia is interesting only because it makes sustainability even more remote. While Ca125 has a place in investigation, it is of such low sensitivity and specificity[3] that it cannot be routinely used in dyspepsia. When the NICE guidelines on heavy menstrual bleeding were first adopted, one PCT noted that it was spending in excess of £20K on unnecessary TSH tests!

Michael Balint[4] may have had sustainability in mind when he wrote his book, *The Doctor, His Patient and the Illness*. How many GPs still collude anonymously with their patients and colleagues? It is so easily done and often, mistakenly, saves the consultation or helps terminate it!. But 'collusion of anonymity' is wasteful of resources and inimical to sustainability. Above all else it is an illusion of good medicine and perpetuates the myth of the 'nice' doctor.

One is also persuaded by the power of the doctor as the most potent therapeutic intervention in the consultation. GPs no longer seem to have the time to discuss risks/benefits with patients, but now need to be willing and able to reclaim their professionalism and engage more with patients. Therein lies the key to good medical practice and sustainability.

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The postcode lottery of GP training: Time Out of Programme

I was encouraged to read the article by Franey *et al*[1] about the undoubted value of an international Time Out of Programme Experience (OOPE), particularly in a low or middle income country. In the Severn School of Primary Care (Severn Postgraduate Medical Education) we have been promoting this activity for 5 years, inspired by the Crisp report.[2] The many gains[3] that accrue have informed our selection criteria: how will the OOPE benefit the candidate's career progression, general practice in the NHS, and the health of the country of the placement, and why does the OOPE need to be taken at this particular time?

To date we have had overseas OOPE doctors (OOPEs) in Uganda, Malawi, Madagascar, KwaZulu-Natal, Solomon Islands, Zambia, Northern India, Costa Rica, Nicaragua, and the Cook Islands. Short descriptions of their inspirational experiences are available on our website: http://www.primarycare.severndeanery.nhs.uk/training/trainees/out-of-programme-experience-and-opportunities-oope/our-recent-oope-trainees-and-what-they-got-up-to/

We finance placements for our intending OOPEs on a local 3-day course in overseas medicine, which is aimed at doctors and nurses preparing to work in low resource countries. We provide a series of in-house meetings where returning OOPEs share their experiences and potential OOPEs have an opportunity to discuss preparatory arrangements. We emphasise and try to ensure that all our OOPEs have clinical