

direct a patient who still needs nursing to a private nursing home it may well be breaking the law.

The circulars state that arrangements for discharge to other than the patient's home must be made in good time and be acceptable to the patient and, where appropriate, the patient's carers. Where a person moves from hospital to a private nursing home it should be made clear to him or her in writing before the transfer whether or not the health authority will pay the fees under a contractual arrangement. No NHS patients should be placed in private nursing homes or residential care homes against their wishes if it means that they or their relatives will be personally responsible for the charges.

Up and down Britain cash starved hospitals, desperately trying to cope with an aging population, are discharging patients to nursing homes. They are probably breaking the law by not providing for the sick elderly, and it is an interesting legal point whether the hospital or the consultant could be held responsible for paying the family's expenditure.

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1 Hilton AM. Aging: should it be left to chance? *Br Med J* 1989;298:1385. (20 May.)

Relief care and risk of death in psychogeriatric patients

SIR,—In our original article¹ we clearly defined the two groups of patients studied as those whose admission was unplanned and in whom no medical or rehabilitation cause was found (social) and those who had an elective admission to give the carer a break (respite). There was no inappropriate designation of patients as suggested by Dr P McCaffrey and colleagues.² It is indeed a pity that they, like Drs S Selley and M Campbell,³ who looked only at respite care, chose not to compare like with like—that is, their data on respite care with our data on the respite care group. The mortality in this group was 9% and not 22%.

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Life sustaining technology: making the decisions

SIR,—In his response¹ to Professor Brian Williams's editorial² Professor Bryan Jennett only touches on the heart of the problem—that is, what do doctors perceive their duty to be?

This has been neatly summarised by Professor Gordon Dunstan,³ whose view is that doctors have two fundamental duties. The first is to protect the patient's natural right to life, and to this end doctors use their diagnostic and therapeutic skills. The second is to protect the patient's natural right to die. Fulfilling this duty does not oblige doctors to end life deliberately any more than their first duty obligates them to endeavour to create life. It does, however, oblige them to recognise when curative and supportive measures cannot save life but simply prolong dying.

In intensive care medicine substantial progress has been made in recognising when this point has been reached. The contribution of age, previous

health, physiological scoring, and the underlying diagnosis has recently been summarised in an extensive study.⁴ These factors combined point to the likely outcome, and the decision to withdraw life sustaining technology is a judgment based on them. Making this judgment is not an option to be exercised at doctors' discretion but a duty to be performed in the patient's best interests.

If as doctors we were more willing to recognise and carry out our second duty there might be less pressure to establish written protocols and living wills.

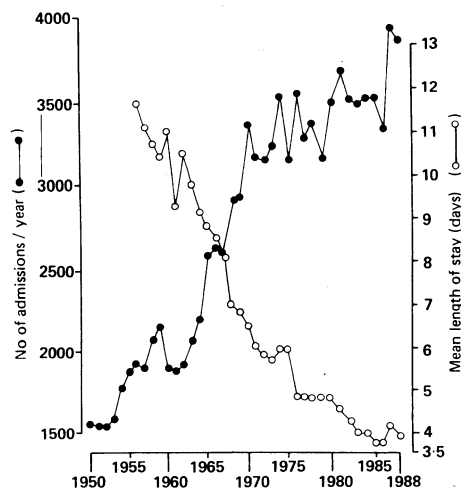
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Trends in paediatric medical admissions

SIR,—Dr Alison M Hill has exemplified a well recognised change in the pattern of paediatric admissions.¹ This change, comprising more admissions and a shorter duration of stay, has also occurred in the Royal Hospital for Sick Children, Edinburgh (figure). The reasons that Dr Hill advances for the change and some of her conclusions lack clinical insight and if accepted might well put children at unnecessary risk.



Medical admissions and mean length of stay, Royal Hospital for Sick Children, Edinburgh, 1950-88

The role of a children's hospital and department is no longer that children should be admitted only when they are seriously ill, and this concept should not determine bed complements. Accurate early diagnosis and treatment have played an important part in reducing mortality in many childhood diseases—in 1950 nearly 400 children in Scotland died of pneumonia or bronchitis compared with 19 in 1987. In childhood early signs of serious disease may differ little from those of minor illnesses. Any suspicion of serious disease demands early accurate diagnosis, which is often impossible without using modern hospital techniques. Waiting to see if an early suspicion of meningitis is fulfilled or if mild croup will develop into obstructive laryngotracheitis can put a child at serious risk. Critical retrospective judgments on the propriety of the admission of children whose condition was subsequently diagnosed by hospital investigation

is unjustified hindsight. At the time of admission the diagnosis may have been obscure. Recently there has been much closer rapport between general practitioners and paediatricians, whereby general practitioners more readily seek the correct diagnosis and treatment that early hospital admission offers and paediatricians more confidently return their patients early to general practitioner care. Paediatricians are anxious to keep children out of hospital but not to an extent that puts their patients at risk. Ready recourse to early hospital admission, with mothers staying with their children whenever possible, is an important preventive measure.

Regarding the increase in admissions, Dr Hill suggests that "if necessary, ways of controlling and coping with it must be sought" and avers that the "unexplained rise in admission rates . . . is an important reason for the current financial problems in the acute services." The increase is not unexplained. Curbing admissions would entail needless clinical risk, and whether it would reduce costs is open to question because of prolonged stays resulting from delayed diagnosis.

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1 Hill A. Trends in paediatric medical admissions. *Br Med J* 1989;298:1479-83. (3 June.)

Myalgic encephalomyelitis and muscle fatigue

SIR,—Myalgic encephalomyelitis (postviral syndrome, fatigue syndrome, effort syndrome, neurasthenia) has been much discussed in your journal recently. In particular Dr C Shepherd¹ seeks to diminish the importance of the findings of Stokes *et al*, who showed that patients with myalgic encephalomyelitis had no evidence of muscle weakness or abnormal fatigability.² Dr Shepherd pointed out the evidence for persisting viral infection and reduced protein synthesis in skeletal muscle found by other workers in patients without explaining how these abnormalities would cause the symptoms of myalgic encephalomyelitis. One might as well seek to prove that England's football team won the World Cup in Mexico in 1986 by saying that Lineker was the leading scorer, Shilton was the best goalkeeper, and England played some very attractive football. Unfortunately, although all these things are true, England did not win the trophy, and equally unfortunately for those who seek to explain the symptoms of myalgic encephalomyelitis on the basis of muscle disease there is no evidence that patients with myalgic encephalomyelitis have abnormal muscle fatigue, however tired, washed out, or exhausted they may feel. It is not constructive to speculate on the possible mechanism of muscle fatigue, since there is none: such an approach is unlikely to benefit the patients.

The presence or absence of persistent muscle or blood enterovirus infection is irrelevant in a population of patients largely self selected because of a history of antecedent viral symptoms. The finding of decreased muscle protein synthesis does not readily explain the disproportionate fatigue which these patients complain of. When muscle protein synthesis is greatly reduced—for example, in patients with Duchenne muscular dystrophy³ or in otherwise fully mobile patients with fractured tibias after leg immobilisation⁴—fatigue is not a prominent symptom. Furthermore, of the two abstracts presented by Dr Peters's group mentioned by Dr Shepherd and purporting to show reductions in protein synthetic rate in patients with the postviral fatigue syndrome,^{5,6} one does not adequately define the control subjects studied and the other compared a study group of relatively inactive 38 year old women with a control