BRITISH
MEDICAL
JOURNAL

SATURDAY 22 JULY 1972

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO. 5820 BRITISH MEDICAL JOURNAL 1972 VOLUME 3 189-250
ASTM CODEN: BMJOAE 3 (5820) 189-250 (1972)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR TELEPHONE 01-387 4499
WEEKLY PRICE 42p

CORRESPONDENCE

Correspondents are asked to be brief

Distress of Dying

SIR,—It is becoming generally recognized that the current management of terminal illness is often very inadequate as regards the provision of relief from mental and physical suffering, and the article by Dr. W. Dewi Rees (8 July, p. 105) is timely. The management of death and dying is an inescapably important part of medical practice, but it is rare indeed for it to be given a formal place in the crowded medical curriculum, although several useful programmes have been developed in the U.S.A. In my experience in Britain, teaching medical students, nurses, and social workers in training, the students are often very aware of the lack of useful guidance in this subject, and eager to learn about it. As the work of such pioneers as Elizabeth Kubler Ross[1] and Cicely Saunders has shown, dying need not necessarily be a harrowing, uncreative, or unrelieved experience, and thoughtful and imaginative management can relieve so much of the suffering. I was struck by the recent comment of the friends of a great man who died at their home: "We wanted him to die in peace, rather than in hospital." These don't need to be alternatives.

But while Dr. Rees's study is interesting, it is not at all clear how one can interpret his findings. In the area he studied 74% of deaths occurred in hospital and 26% at home. This is in accord with the general pattern of an increasing proportion of deaths occurring in hospitals and similar institutions shown in the United States, for instance, where in 1949 49·5% of deaths took place in hospital, and in 1958-60 the proportion was 60·9%.[2] But when he shows that patients dying at home were more likely to be alert shortly before death, and less likely to suffer from vomiting, incontinence, bedsores, or unrelieved physical distress the significance is obscure. Are not those patients with incontinence, bedsores, persistent vomiting, or unremitting pain just those who are most likely to be admitted to hospital for terminal care, and much less likely to be discharged from hospital? Those classified as "dying at home" are also likely to include a higher proportion of those dying shortly after the onset of the illness, and, other studies suggest, likely to show a different pattern of illness, with a higher proportion of deaths from suicide, homicide, and accidents, as well as heart disease. The differences Dr. Rees has noted may indeed represent some differences in terminal care, but are more likely to be owing to the study of different patient populations. The data for duration of terminal illness is not comparable with other work in this area, as it was based on "the decision of the nurse that the patient was dying"—a subjective decision that tells as much about the nurse as about the patient.

Dr. Rees could add greatly to our knowledge by studying the factors that determine where the terminal patient is treated; and why, even in good and compassionate hands, 14% suffered from severe anxiety, 12% from such severe depression that at times they wanted to die, 34% suffered incomplete relief of their pains, and 28% were at times "never free from their distress throughout the day." When we know that, perhaps patients can die in peace and in hospital.—I am, etc.,

MICHAEL A. SIMPSON

Guy's Hospital,
London S.E.1

[1] Kubler Ross, Elizabeth, *On Death and Dying*, Tavistock Publications, 1970.

[2] *The Dying Patient*, ed. O. G. Brim, H. E. Freeman, S. Levine, and N. A. Scotch. p. 24. New York, Russell Sage Foundation, 1970.

SIR,—Dr. W. Dewi Rees's investigations into dying (8 July, p. 105) show that 28% of his patients at Llanidloes were fully alert 24 hours before death and 12% wanted to die. Only 26% were devoid of physical distress. Here indeed is concrete evidence of the need to break through the wall of prejudice with which we surround the dying. When death is inevitable, to deny its fulfilment to a person who desires it is little removed from being an accomplice to torture. Once again the urgent need to introduce voluntary euthanasia is clear, as it has been to many—both laymen and doctors—who have attended the dying over the years.—I am, etc.,

S. L. HENDERSON SMITH

Huddersfield, Yorks

Pulmonary Oedema of Mountains

SIR,—Your leading article "Pulmonary Oedema of Mountains" (8 July, p. 65), although an appropriate and timely warning to the increasing number of people going to high altitude, contains some misconceptions.

Women mountaineers do indeed suffer from this illness. In the Himalayas I have experience of four women suffering from acute mountain sickness; three were manifest as high altitude pulmonary oedema and one as cerebral oedema. One of the patients,[1,2] who is a nurse and an experienced mountaineer, gave a clear story of having severe premenstrual tension before she developed pulmonary oedema. Evidence suggests that women who have an exaggerated periodic physiological water retention (antidiuresis[3]) with migrainous headaches, irritability, rapid weight gain, and peripheral oedema may be more susceptible to acute mountain sickness.

I suggest that women going to altitude should take a mild diuretic prophylactically during the premenstrual period. A specific improvement has been claimed for the prevention of acute mountain sickness by acetazolamide (Diamox).[4,5]

Diuretic therapy, using frusemide (Lasix), has proved to be lifesaving if given early enough, but its danger must also be appreciated. During acclimatization the plasma volume diminishes hand in hand with a