Enforced retirement

An age of retirement, of becoming an old age pensioner, must be directly related to some kind of anonymous, partly social, partly medical, assessment of many complex factors, though it is full of anomalies. For example, if women have a greater expectation of life than men, men should get their free bus passes at 60 while women soldier on until they are 65. As a profession we should try to devise the best rule for the age of retirement on the grounds that such an age is most properly determined by the actuarial likelihood of brain failure. We may well select 65 as the age of retirement, even though there are many instances of much longer durations of brain excellence individually. It may be wise that several brilliant surgeons lay down their scalpels at 65 so that one failing operator may be prevented from causing harm to an occasional patient.

If this is our decision then we must ask for its general application. We must go further and insist that there is regular and detailed medical surveillance of all those who take on themselves the tasks and powers of directing the lives of hundreds, thousands, millions. The House of Commons often keeps ridiculous hours for important decisions, which would not be acceptable to any other profession or trade. If the least lapse of a main-line locomotive driver results in his being relegated to office work or, at best, shunting, how much more important is proper medical scrutiny for, say, members of the Cabinet, of the Houses of Lords and Commons, board members of great corporations, High Court judges. The brains of every member of the Commons could be scanned in a month (using a single CAT scanner 12 hours a day, every day of the week). The medical profession should organise a campaign towards these ends on the same lines that have been used in campaigns against smoking and for the enforced use of crash helmets and seat belts. Such work, of conflict

and persuasion, would historically be similar to that which ended transportation, ensured clean water and adequate drainage, and brought women the vote and retirement pensions for the elderly (1906 in this country, 56 years earlier in France).

Politics of prevention

If we perceive a danger of brain failure lurking, in a hundred different causes, behind almost any illness, at almost any age, will any of us bring that recognition to wider notice? If we feel that retirement is rightly based on what has so far been a sub-conscious estimate of medical statistics the age of retirement must be applied as a rule without exceptions. Arising from the rule is the conclusion that up to the universal age of retirement the more important and powerful a post anybody has, in relation to the numbers of people he manages, the more stringent should his medical assessment be. The sole purpose of such examinations would be preventive and not punitive: for many of the causes of brain failure are treatable if detected in their early stages, and some of the causes are entirely avoidable.

References

- ¹ L'Etang, H, *The Pathology of Leadership*. London, Heinemann, 1969.

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Dying children need help too

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The control of symptoms in dying children is often sadly neglected. This neglect is reflected in a review of the case notes of two children who died of cystic fibrosis within three years of each other. The girls were under the care of the same consultant, who in the interval between the two cases was introduced to the concept of proper terminal care for children.

Child 1

This child was found to have cystic fibrosis at the age of 6 weeks, her parents having already had two affected children. Her sweat chloride concentration was 302 mmol (mEq) l. Her clinical course was typical of the disease. At the age of 9 years she was admitted after a week of increasing breathlessness and troublesome, productive cough. She was dyspnoeic, cyanosed, and feverish. Her chest signs and radiograph were characteristic of fibrocystic disease with added infection.

She was at once put into a humidified oxygen tent and encouraged to drink. Her maintenance antibiotics were changed and physiotherapy intensified. After admission her condition deteriorated, so fluids and antibiotics were given intravenously from the second day. She was

cyanosed and restless but conscious, orientated, and unable to sleep. On the sixth day she went into congestive cardiac failure, requiring frusemide and digoxin. During the six days she had been seen often but inconsistently by three senior house officers, two registrars, and two consultants—holidays and off-duty periods interfering with continuous care by any one doctor.

Active management continued, with numerous blood gas analyses and several changes in antibiotics, but staff were clearly slow to realise either that she needed relief for her symptoms or that this was a terminal illness.

On the seventh day the nursing notes repeatedly stated that she was "very poorly" and "has not slept." She had also complained of pain, for which paracetamol was given. At the child's request her special calorie and protein-rich diet was stopped. On this day, her mother left on top of the oxygen tent the sadly inappropriate gift of a painting book. The next day the child died. Her parents were not present. Throughout her illness they had made a few short visits. They had somehow eluded an interview with the medical staff.

Child 2

This girl also had siblings affected by cystic fibrosis. She was 19 months old before her sweat chloride was unequivocally raised to over 200 mmol/l despite a suggestive story of recurrent chest infections and diarrhoea. She was 7 years old at the time of her admission. Her recent history and clinical findings were similar to those in case 1.

On admission active treatment was started with humidified oxygen, intravenous fluids and antibiotics, bronchodilators and mucolytics, sodium cromoglycate, and physiotherapy. Occasional episodes of chest pain, dyspnoea, and panic after coughing were controlled with paracetamol and diazepam regularly by day.

On the 11th day clinical improvement began and the drip came down. She was mobilised and was beginning to enjoy toys, television,

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and friends on the ward when she had to go into isolation with an intestinal pathogen on day 15. Her condition remained static for the next seven days, but she could not go home because of the risk to younger siblings of gut infection. On the 23rd day she relapsed with severe dyspnoea and cyanosis, again needing oxygen, intravenous fluids, and a change of antibiotics. So far, recovery had been hoped for, but it was now realised that this was likely to be her final illness. Her parents had maintained close contact with their child and with the medical and nursing teams, and they gradually began to accept that the aim was no longer cure but comfort.

The isolation cubicle had the advantage of privacy, allowing quiet conversation, personalised television, or music. With the ward staff's understanding, a simple service of prayer was held there on the 34th day of her admission. Although clearly aware of the implications, she as always displayed remarkable excitement and confidence about "going to heaven," without any discernible fear of death. Her parents had clearly supported her well and this day was evidently one when the whole family found a degree of consolation.

After this all drugs and diet unrelated to controlling her symptoms were stopped, as was aggressive physiotherapy. At the onset of distressing dyspnoea a continuous infusion of diazepam was started, the dose being titrated against symptoms until agitation stopped. Diazepam given round the clock, helped the child to ignore dyspnoea by day and allowed sound sleep at night. On the 45th day distress recurred. A random injection of intramuscular papaveretum hurt and upset her and it was agreed to use oral or intravenous drugs only. The next day her condition remained cheerful and chatty (still on diazepam) despite severe dyspnoea. On the 47th day the drip was removed so that her parents could hold her. Syrup of diamorphine with cocaine was substituted in six-hourly doses throughout the night and into the next day, and she became semiconscious. Suddenly she struggled out of bed, smiled happily, and hugged each parent in turn before dying quietly in her father's arms.

Discussion

These two cases show that illness can cause physical, emotional, and spiritual pain to family and staff. In retrospect these areas of distress were not clearly defined in either case and opportunities to alleviate suffering were missed. The first child received virtually no symptomatic relief, and the remembrance of her last days was still painful to the nurses three years later. This hindsight helped to inspire more determined efforts to help the second child.

The omissions in care were partly due to constantly changing medical staff, who also failed to register observations made in the nursing notes. These adequately described both children's feelings but may never have been read by a doctor until this review and were clearly not communicated properly. The failure hinged on the fact that neither nurses nor doctors realised their own potential for relieving symptoms.

Physical pain—Both children experienced dyspnoea and attacks of coughing with chest pain. Even though it was not immediately realised that the first child was dying, symptom relief should have been thought of. She actually received only one dose of paracetamol. In case 2, however, there was a definite attempt to titrate treatment against symptoms using mucolytic and bronchodilator agents and regular analgesics.

Emotional pain—We are not aware how much emotional pain the first child suffered. The second experienced fear, imprisonment by her oxygen tent, dislike of diet, and insomnia. Her fear was alleviated by the willingness of both her parents and the staff to talk openly with her, by diversional activities, and by anxiolytic agents. Finally, all treatment was stopped except that needed for controlling her symptoms.

Spiritual pain—We have found that many families suffer in spirit during a terminal illness and some turn desperately to faith healers. Such people need understanding, not criticism. In case 2 the parents each had an active Christian faith, which clearly saved them from overwhelming fear and despair. Speaking of their child's last moments, her parents could later say, "This was not passing from life into death, but from death into life." Their experience may comfort others.

Family and staff pain—In the first case we can only guess at

how much her family suffered: we know that the staff had painful memories. The parents and sisters of case 2 received much help and with the caring staff had mutual support. This has continued in bereavement follow-up.

The principles of controlling symptoms need to be remembered as much during distressing treatment as during the distress of dying. There are, however, few published guidelines for use in childhood. Children suffering from renal failure, respiratory failure, and malignant disorders will need such help at intervals throughout their illness—from the initial biopsies, during radiotherapy and chemotherapy, to the end. We already know that diazepam does not suit all children^{1,2} and are now doubtful whether cocaine should be used at all.³ Studies are needed on the value of antiemetics, on the regular giving of oral opiates, and on the metabolism and interaction of drugs in childhood. We believe that these problems are often encountered in the major treatment centres and that the experience gained in such management needs to be pooled and shared. Just as important, we also need to know whether such regimens could be managed in the home.

Even in childhood it is important to treat the whole person and also to see the child in the context of the family. Only by thinking in these terms shall we learn what can be done to help all members of the family to come to terms with their loss.

References

- 1 Brett, E M, *Developmental Medicine and Child Neurology*, 1970, **12**, 655.
- 2 Shaffer, D, *Child Psychiatry: Modern Approaches*, ed M Rutter and L Hesor. Oxford, Blackwell Scientific Publications, 1977.
- 3 Twycross, R G, in *The Management of Terminal Disease*, ed C M Saunders. London, Arnold, 1978.

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What is the treatment for severe, disabling epiphora in a woman of 73? Her ducts are patent. There is no corneal or lid lesion and she has no ectropion.

Epiphora is usually defined as the overflow of tears resulting from inadequate drainage and does not include watering due to excess lacrimation. Patients not infrequently complain of "eye watering" when there is irritation of the eye and no actual epiphora; so it is important to ask whether there is actual overflow of tears. If the patient is confident that the tears do overflow and on examination the tear fluid in the marginal gutter of the eye lid is seen to be excessive then epiphora can be diagnosed. Epiphora results from poor drainage of tears due to ectropion of the eyelid; ectropion of the lacrimal puncta alone; stenosis of the lacrimal punctum, canaliculus, or sac; or obstruction of the nasolacrimal duct. The patency of the tear drainage apparatus is investigated by dilatation of the lacrimal puncta and syringing the tear ducts. If the anatomy is normal and a free flow of fluid to the nose is obtained then the lacrimal drainage is probably effective. A dacryocystogram, which is an easily performed x-ray investigation with contrast medium injected through the lacrimal puncta, will confirm the anatomical normality of the lacrimal drainage passages. Confirmation of effective flow can be obtained from the Lester Jones primary dye test, in which fluorescein eye drops are placed in the eye and the passage of fluorescein demonstrated in the nose by cotton wool inserted in the inferior meatus. A new technique using scintillation radiography also tests the flow, but is available at only a few centres. If the investigation of the lacrimal drainage suggests that it may be poor, although patent to syringing, then it is worth offering the patient a dacryocystorhinostomy operation. If good lacrimal drainage is confirmed by investigation then tear overflow is likely to be due to excess secretion. An irritative cause should be sought and treated. In the absence of any treatable cause eye drops containing zinc sulphate 0.25% with phenylephrine hydrochloride 0.125%, three times a day, can help. As a last resort partial dacryoadenectomy may be considered.