CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Audit in renal failure

SIR,—Renal physicians can justifiably claim that collectively, through the European Dialysis and Transplant Association and national transplant-sharing organisations, as well as individually they have done more than any other group to audit their practice and to provide information concerning the complications, outcome, and costs of dialysis and transplantation for end-stage renal failure. It is therefore disappointing that a professional research organisation such as the Study Group of the Royal College of Physicians should not consider the extensive literature[1-10] before reaching conclusions concerning the availability of resources to treat end-stage renal failure (25 July, p 282). It must be unusual for a paper with conclusions at variance with and in apparent ignorance of so much published data to be accepted by the *BMJ*. Unfortunately, the general public and their appointed representatives, who the authors claim are being misled, are more likely to be misled by the publication of such a paper, even with editorial criticism both in your journal (p 261) and in *The Times* of 24 July to balance the issue.

While the Study Group's remit was to consider only mortality under the age of 50 years, conclusions drawn from such an analysis must be put in the context of the overall problem. It is well known, as your leading article emphasises, that facilities for treating patients over 45 years of age are less adequate in the United Kingdom than in most developed non-socialist countries and that the incidence of chronic renal failure rises logarithmically with age. Under these circumstances, to foster a feeling of complacency when the main question of treatment for those over 45 years of age has not been addressed, and when the epidemiological techniques used are unsound, is unacceptable. This begs the question of whether or not the grounds for non-treatment in individual cases cited under the age of 50 years would be unchanged given better resources, though we accept that for some people with renal failure the severity of other problems must reasonably exclude dialysis or transplantation. The publication of details of the reasons for non-treatment of patients with renal failure is valuable, but it is wrong to broaden the conclusions drawn far beyond the limits imposed by the data given.

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SIR,—As recently appointed nephrologists to the West Midlands, we would welcome the opportunity to comment on the study on deaths from chronic renal failure under the age of 50 from the Medical Services Study Group of the Royal College of Physicians (25 July, p 283).

Like you, we are surprised that this study should originate from regions that like ours have an appalling record for the treatment of renal failure judged by either national or international standards. The authors fail to comment on the obvious discrepancy between the number of new patients being accepted for treatment in these regions (17 per million of the population per year in the West Midlands) and the expected population at risk under the age of 50 (30-40 patients per million of the population per year). We would like to make a few specific points.

(1) In the nine months since the first of us was appointed, 25 patients have been started on dialysis at this hospital and a further 17, close to requiring dialysis, have been seen and accepted for treatment. In the two years preceding our arrival a total of 21 patients were started on treatment. This change is directly attributable to the increase in the number of nephrological sessions.

(2) Yet again resources for the treatment of renal failure are being equated with dialysis machines. This, as all nephrologists know, is far from being the whole story. Having previously been extremely limited by a shortage of nephrological sessions this, the main teaching hospital in the West Midlands, is struggling with lack of space, insufficient numbers of nurses and paramedical staff, and inadequate funding.

(3) Rationing of resources can be achieved by creating a low expectation of the service as well as by limiting funds. It is a fact that in this part of our region the previous level of service has led to patients not being referred to renal units because expectations were so low. Thus selection was, and still is, being done by general physicians or family practitioners, who may not know what is possible or ought to be possible in the treatment of renal failure in 1981.

(4) The design of the study was such that a considerable number of patients could have been missed. The authors admit that patients under the care of a general physician but not referred to a nephrologist would not have been included. The report comments that they "... do not think that the numbers would have been large enough to have affected their conclusions." The available statistics would suggest otherwise.

(5) The decision to examine only those deaths under the age of 50 seems strange and somewhat arbitrary in view of the success achieved in treating patients older than this. Similarly, the statement that there is a substantial group under the age of 50 unsuitable for long-term treatment is open to question, particularly on the evidence presented. Many of the patients left untreated—for instance, the diabetics—might, from the limited details given, have been accepted by other nephrologists. Moreover, many of the patients who died early in the course of their treatment might not have done so had the facilities been more readily available and hence treatment instituted earlier.

We feel that this report is an inadequate and misleading account of the availability of facilities for the treatment of renal failure in this area and that it could well hinder attempts to improve the service.

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SIR,—I have read with interest and also with consternation the report by the Medical Services Study Group of the Royal College of Physicians (25 July, p 283). My consternation concerns the reasons for not offering dialysis or transplantation to certain categories of patients.

Some reasons are acceptable without argument—for example, mental subnormality or age limitation—but I am surprised that clinical decisions should be made on the basis of such reasons as the patient being an orphan, obese, not having worked for 10 years, having an uncooperative husband, being separated from wife and family, or having no home. Above all, I am astounded that some patients were rejected because they "spoke no English." Perhaps my reaction is influenced by the fact that I too spoke no English when I first came to your country as a medical student in 1952. In at least two cases (1214, 1217) the lack of knowledge of English seems to go with tuberculosis, but surely a cure now exists for both the tuberculosis and the lack of knowledge of English in these relatively young patients (41 and 33 years). In the case of patient 1214 a further question comes to my mind—if the fact that she "spoke no English" was a pertinent reason for not dialysing, how was the psychologist able to diagnose "instability"? Are British psychiatrists and psychologists more competent in foreign languages than nephrologists, or do nephrologists make decisions in a more haphazard way?

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SIR,—One of the objectives of the Medical Services Study Group (25 July, p 283) was to reassure the public that the supply of services for end-stage renal failure in the three regions are meeting the demand.

The first anxiety is that the public over 50 were not considered. This is the very area where the provision of services in the United Kingdom as a whole is strikingly less than that provided by our colleagues in Europe.[1]

If it is conceded that between 30 and 40 patients per million per year should be offered treatment for end-stage renal failure,[2] the regions surveyed should be generating between 480 and 640 patients. In the two years considered they totalled only 384, suggesting a significant shortfall (even if all the patients in the West Midlands who were transplanted were not included in the newly dialysed patients).

In a survey of death certificates in the South-east Thames Region (population 3 million) considered in 1976, 354 under the age of 65 had renal failure mentioned as one of the causes of death. All the certificates were circulated to the appropriate one of the five renal units in our region. The majority were recognised, but deaths in the home and in peripheral hospitals revealed 41 (12%) patients who had not been considered by renal units, although not all necessarily would have been treated. This is the most worrying feature of the MSSG report—the unreported patients must represent over a two-year period, on our estimate, at least 164 patients (twice the population over two years $\times 41$). That patients were arriving late for treatment is partly due to the nature of renal failure, but for 38% of the deaths to occur within three months of acceptance suggests that a proportion were referred too late to be helped.

If we turn to those refused treatment, the problem of not treating the blind, the diabetic, the socially disadvantaged, and those unable to speak English is of such ethical importance that we cannot agree that such decisions reflect current nephrological opinions, as highlighted by our own small study.[3] We share the view of *The Times*[4] that this cannot reassure the public that all is well. We were surprised that no mention was made of the presence of hepatitis as a cause for exclusion, but we can only assume that it was not the case, as it is still in a proportion of renal units.[5]

We hope that this study will be used rather to open more units for treatment of renal failure in such needy areas, and also that patients' right to early treatment and to a second opinion where they are refused treatment will be observed.

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[4] Anonymous. *The Times* 1981;July 24:15.
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SIR,—We welcome your leading article "Audit in renal failure" (25 July, p 261) and entirely agree with your assessment. At the same time we feel that due credit should be given to the Royal College of Physicians for bringing some problems into the limelight.

We were particularly struck by the fact that three patients under the age of 41 who were turned down for renal replacement therapy had the common denominator that they spoke no English. Although language could be a barrier between staff and patients, our experience has been otherwise. We have had the pleasure of placing patients on home haemodialysis in the UK and on the continent of Europe who spoke no English or any other language spoken by the dialysis team.

We are also aware of four other occasions in other regions where besides the language barrier and shortage of kidney machines the patient's poor compliance with treatment was used as a pretext for denying treatment. Two of our patients who do not speak a word of