VIEWS & REVIEWS

"They wouldn't teach us this if it was pointless!" Des Spence on the bad medicine in digital rectal examination, p 1266

REVIEW OF THE WEEK

Reflections on ageing

These tales of ageing in a book by a geriatric psychiatrist reminded **Desmond O'Neill** why he became a gerontologist

How We Age: A Doctor's Journey into the Heart of Growing Old
A book by Marc Agronin
Da Capo Press; £14.99
ISBN 9780306818530
Rating: ★★★☆

As a child I was fortunate to experience a wide range of older people. That all four grandparents had dementia mattered not a whit to us as children. One grandfather made tea using tobacco; the other reverting to moistening his cheroots by inserting them completely into his mouth as he had learnt in the trenches at the Somme. With or without dementia, their independence of spirit was notable and intriguing. Our unquestioning acceptance of them, and of some highly individual great aunts, was tempered and transmitted through the lens of care, interest, and engagement shown by my parents and their family.

I have no doubt that these experiences influenced my choice of career, and the vast majority of geriatricians share this abiding sense of enjoyment and fascination of working with older people, the most complex, enriched, and challenging of patient groups. To us it is not unsurprising that several studies have shown that career satisfaction in our specialty is higher than for almost all other specialties.

And yet it is still clear that many healthcare workers have a troubling moral and professional blindness to the humanity and complex care needs of older people, as highlighted recently by the recent shocking report of the UK Health Ombudsman on the care of older people.

The unanswered question in such reports remains how the education, altruism, and professionalism of large groups of healthcare workers have been subverted to such a dismissive attitude to those with the greatest need. Complexity is clearly one challenge, whereby a retreat to task or organ focused medicine may seem to be an enticing shortcut, but one that diminishes and demeans both carer and patient.

A deeper problem lies in appreciating the value of existence of life at advanced age, or with cognitive impairment. The rhetoric of "a good innings" is all too pervasive, as is the unhelpful depiction of dementia as a marker of dehumanisation rather than a series of impairments wherein our challenge is to engage with the person in radically altered circumstances.

Those who teach geriatric medicine and gerontological nursing are faced with a pressing need to articulate more clearly the remarkable nature of later life, the possibilities of change and growth in the face of loss, and the definition of the very real bonus of wisdom in a way that is not eroded by mawkish sentimentality.

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A medical humanities approach can tease out not only these complexities but also our own fears and aversion as practitioners. The mature output of great artists is a potent metaphor for what we gain with ageing, and enlightened ethicists, such as Stephen Post in his *Moral Challenge of Alzheimer Disease*, are beacons of lucidity and inspiration for recognising the fullness of life with dementia.

Yet the more pragmatic students and practitioners may be resistant to these high concept approaches, and there is a crying need for an articulate physician to provide a road map to the meaning of old age, framed in a clinical context that will resonate in a realistic way with healthcare workers.

Marc Agronin makes an impressive start in *How We Age: A Doctor's Journey into the Heart of Growing Old*. An articulate and imaginative geriatric psychiatrist in Florida, his book resembles Sherwin Nuland's ground-breaking *How We Die* or Atul Gawande's *Complications* in its adroit and successful marriage of gritty clinical practice and big ideas. Each chapter focuses on one or more patients and draws on philosophy, developmental psychology, Judaism, gerontology, geriatric medicine, and psychiatry to make sense of ageing, advanced dementia, and the possibilities of growth and reconciliation.

Agronin: gritty clinical practice and big ideas

The delivery is crisp and the narrative turns often surprising. The description of a seminar with the ageing Erik Erikson looks as if it is shaping up to be a cringe making *Tuesdays with Morrie* fest of adoration at the feet of the sage, until he starts factoring in Erikson's evolving dementia. What is most impressive in this is Agronin's ability to make us see a context and sense to these changes, not so much sugaring a pill as drawing some of the poison of popular stigma from conditions to which older people and their families often make surprisingly good adaptation.

Counterpointing some of the older people's stories with the traumas of their earlier years—many are war veterans or Holocaust survivors—reminds us not only of the relevance of old age as a time when we make sense of life, but also the real possibility that life can indeed be better in some ways. It also leads to a wonderful defence of "unreasonable" and "exasperating" behaviour. We also get insights into the importance of gerontological expertise, hope, and, most crucially, a true sense of how stimulating care of older people can be with the right attitudes, skills, and approaches.

This anthology of reflections does much to restore old age as an epoch of equivalent (if not superior) value as the other stages of life, and is well written and entertaining. If the unexamined life is not worth living, we are fortunate that Agronin's examination of later life allows us to appreciate its surprisingly rich vitality.

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BETWEEN THE LINES **Theodore Dalrymple**

A healthy island

The first tourist guidebook to the island of Sark, as far as I know, was written by a doctor, G W James, in 1845. The guidebook is understandably short, the island being so small; but the author, being a doctor, devotes an eighth of it (14 pages) to medical matters.

Sark, on the face of it, was not an exciting place to visit: "To those whose minds are only kept in motion by the aid of others, or by the attractions of the billiard-table and news room, Sark might, after a cursory view, prove a source of *ennui*."

But Dr James offered some reassurance to nervous visitors to so remote a destination: "It may here be observed as important to visitors in the event of sickness or accident, that a surgeon now resides on the island, which was not the case until the year 1840."

Till then, islanders and visitors had to send to Guernsey for medical assistance. The combination of "the general healthy condition of the inhabitants" and the complete absence of medical advice spoke well of the island's climate, in Dr James's view, but not necessarily ill of the medical profession, as some ignorant and superstitious islanders had concluded, for whom "fatalism very nearly usurped the place of reason."

"In the year 1832, when Indian cholera prevailed so fatally, there were in Jersey 341 deaths out of 787 cases, and in Guernsey 100 persons were carried off, but not a case occurred on Sark"

The value of medicine as a profession was established beyond reasonable doubt for Dr James by a section on death rates on the island, which is unusually detailed for such a short guidebook. In the four years from 1807 to 1810, he tells us, there were 33 deaths for 300 inhabitants; in the four years from 1840 to 1843, there were 33 deaths for 750 inhabitants.

To no one more than the medical profession is the public good indebted for a diminution of the general mortality. Dr James, the author of *The Sark Guide*, omits to say so in so many words, but the doctor who arrived on the island in 1840 was Dr James, the author of *The Sark Guide*.

Sark was just the place for those worried about their health. There were no epidemics: "During the prevalence of epidemics, this island has escaped miraculously. In the year 1832, when Indian cholera prevailed so fatally, there were in Jersey 341 deaths out of 787 cases, and in Guernsey 100 persons were carried off, but not a case occurred on Sark."

Dr James thought this might be because of the disinfecting iodine and chlorine released into the air by the seaweed, used both for fuel and fertiliser, as well as the constant sea breeze that diluted the infective miasma.

So healthy indeed was Sark that some bad habits might be indulged in with relative impunity: "Irritation of mind and body is known to be a dread destroyer of the human race, but with the prophylactics of simple diet, exercise and tranquillity, even the consequences of excess are kept at bay; in proof of which some of the natives, who are habitual spirit drinkers, have attained a very advanced age. Indeed, if they survive childhood, their most common age of death is between 70 and 90, with as many dying between 80 and 90 as between 70 and 80."

Above all, Sark was an excellent place for cognitive behavioural therapy and graded exercise for the hypochondriacal: "Brace up the nerves and muscles of a timid valetudinarian by a gentle and systematic course of exertion on the hills, and he will gradually become more bold and energetic."

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MEDICAL CLASSICS

The Drugs Don't Work

A song by The Verve from the album Urban Hymns, released 1997

Death is a terrifying part of medicine, particularly for the junior trainee. Despite armfuls of medical terminology and the greater emphasis on emotional intelligence in modern training, nothing is more difficult to say to a patient than that the treatment isn't working.

The indie rock band The Verve had been coasting along nicely in the alternative charts since the early 1990s. But in 1997 their single *The Drugs Don't Work* crashed into the top position in the mainstream UK pop charts, bringing the band to the forefront.

The lead singer, Richard Ashcroft, may have been speaking to his dying father in the song's lyrics: "Now the drugs don't work / They just make you worse." This simple sentiment resonated with millions of people around the globe in the late 1990s, a generation so overexposed to sentimentality that it was sinking slowly into indifference. And the message came through the vessel of an English rock band, the closest thing to poets of the people in our society.

Ashcroft has referred to the "rows of grown men crying" when the band performed the song, "almost like these guys couldn't cry when they needed to cry." His bare solo vocal, famously recorded in one take, brings together the complex ebb and flow of guitar, strings, and percussion, evocative of clamouring emotions, into a single statement. He watches his father's inevitable fate unfold: "Like a cat in a bag / Waiting to drown."

Ashcroft: acknowledging death?

GARETH CATTERMOLE/GETTY

To listen to the repetitive lyrics alone, however, is to ignore the tumultuous activity in the instrumental. A lonely acoustic guitar and a wistful string arrangement perfectly capture the dying patient's vulnerability. Ashcroft's dismal tone in the opening line crescendos as the song progresses, with swelling strings, backing vocals, and rising percussion, bringing us with him to the hopeful refrain, "I know I'll see your face again."

This evolution reflects the journey of the dying patient and their family that the physician must recognise and understand. When our drugs have failed, are patients to be left to make this journey alone? Ashcroft's lyrical journey takes him to a place sometimes more challenging to the medical mind than death—that is, faith. Perhaps the junior trainee standing in front of a dying patient could use the comfort of faith as well.

Listen to *The Drugs Don't Work* at www.theverve.co.uk/index.php?/media/audio/PO/

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Bad medicine: digital rectal examination

FROM THE FRONTLINE
Des Spence

For many years I taught medical students rectal examination using plastic dummies. I explained that largely it was a useless examination, but this met with hostility: "They wouldn't teach us this if it was pointless, Dr Spence!" It was futile to challenge the orthodoxy, so I approached the clinical exams like a drama teacher might approach an end of term school musical. The clinical examiners always said it was "great," but we all knew it was amateurish nonsense. All clinical examinations are in fact clinical "tests," like radiography and blood analysis. They should be subject to the reflective rigour of the positive predictive values, error rates, and the rest.

So does rectal examination have purpose? Inspection has value, to examine for warts, fissures, dermatitis, and piles. But what of the role of digital rectal examination? Logically it has perhaps two purposes: to detect rectal tumours and to palpate the prostate. It has no obvious logical diagnostic value in appendicitis or acute abdominal pain, which were once traditional indications.

Consider the rationale for detecting rectal tumours. The patient presents to the doctor with rectal symptoms. If the patient is young then the possibility of malignant disease is extremely low, so digital rectal examination as screening test has no value. But if symptoms are persistent or in older patients with bleeding, change in bowel habit, or tenesmus this would warrant urgent definitive endoscopy. So how would a digital rectal examination change management? A negative result might offer false reassurance and positive result might be false, generating unnecessary anxiety. Either way this would not change the need for urgent inspection of the bowel.

What about examining the prostate? The "annual" is common practice in the United States but has not been shown to reduce mortality (*Cochrane Data Syst Rev* 2006;3:CD004720, doi:10.1002/14651858.CD004720.pub2, and *BMJ* 2011;342:d1539), and it is associated with a possible rate of overdiagnosis of prostate cancer of 50% (*Br J Cancer* 2006;95:401-5), resulting in unnecessary treatment, destructive surgery, and psychological sequalea. Rectal examination of the prostate may cause more harm than good.

Rectal examination is unpleasant, invasive, and as an investigation has unknown sensitivity and specificity. In a young population digital rectal examination has almost no value, and in older patients may have very occasional and limited indication. It is time to question the once standard practice of routine digital rectal examination because it represents flimsy thinking and bad medicine.

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No news is good news

IN AND OUT OF HOSPITAL
James Owen Drife

When the latest report on maternal mortality in the United Kingdom was published three months ago, there was a small flurry of press interest, focused on a rise in deaths from sepsis (*BJOG* 2011;118:s1, doi:10.1111/j.1471-0528.2010.02847.x). The press interest quickly faded because no one was to blame: most of the infections had been acquired in the community. Had the infections arisen in hospital all hell would have broken loose.

Scapegoats, individual or institutional, are essential nowadays for triggering action in the health and social services. Heads roll, public inquiries are convened, and very occasionally care improves.

There is a better way, exemplified by a news story tucked away in the report.

In the UK the Confidential Enquiries into Maternal Deaths divide causes of death into those that result from pregnancy directly or indirectly. For 20 years the leading direct cause of maternal mortality has been thromboembolism: since 1985 it has killed 272 women. The inquiry soon found that the main risk factors were caesarean section and obesity.

In the early 1990s the idea of guidelines was still controversial, but in 1995 the Royal College of Obstetricians and Gynaecologists recommended on anticoagulant prophylaxis during surgery. These were swiftly implemented, and deaths from thromboembolism after caesarean section fell considerably.

Purists carped that the observation of a fall in deaths was not randomised or controlled, but to everyone else the lesson seemed clear. Deaths from thromboembolism in the antenatal period and after vaginal delivery continued to rise, however, and in 2004 the college produced a new guideline to tackle these deaths. The results finally appeared three months ago. Deaths from thromboembolism have fallen substantially, from 41 in 2003-5 to 18 in 2006-8.

Saving the lives of 20 women is not a big story when nobody, least of all the women themselves, knows who they are. If the media had noticed, they would have asked why it took so long. The answer, unattractive to politicians and bureaucrats alike, is that you need time to get things right. This is why clinicians are so sceptical about instant guidance produced in reaction to shrill headlines.

My long involvement with the confidential inquiries gained me no academic brownie points. Today the inquiry's future is under review. I hope it survives. It convinced me that guidelines are a good thing, and if it can do that, it can do anything.

Competing interests: JOD was a national assessor in obstetrics to the Confidential Enquiries into Maternal Deaths from 1994 to 2011.

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