

Correspondence

Triage and the patient with renal failure

SIR

Drs Parsons and Lock are to be congratulated for their important study published in the December 1980 issue of *JME* where they examined the causes for rejection from entry to dialysis programmes and find that experienced nephrologists are unable to agree on the criteria for rejection and one individual was unable to reject anyone! We have developed the practice of accepting almost everyone who wishes to be treated and then if their subsequent course is unfavourable consider discontinuing treatment if the patient and/or family are in agreement. The reason for this approach has been suggested in this paper, namely that while it is possible in many patients to foresee how they will fare there is a significant number in whom one's predictions are totally incorrect. The patient therefore must be given the benefit of the doubt as is done in other branches of medicine.

What I find disturbing in both the editorial comment and the paper on cost-benefit analysis in the same issue is the tacit assumption that dialysis units in Britain will of necessity have to carry on with the selection because of fiscal constraints. For a developed country that spends millions of pounds on tobacco,

alcohol, armaments etc. and has extraordinary revenue from North Sea oil coldly to deny the opportunity for life to this group of patients has to be seen as inhumane and unethical. The solution is clearly a political rather than medical one and may only be remedied by the force of public opinion.

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Transsexualism

SIR

I read with interest the June 1980 issue of the *Journal of Medical Ethics* – a journal I had not seen before – may I commend you on the concepts and the articles.

My particular interest was in the three papers on Transsexualism – a problem I have had to deal with as the spouse of a man for whom the dilemma of his transsexualism became increasingly overwhelming in his mid-sixties. We have since been divorced, correction surgery has been done, and she is now living comfortably in her new role. Our two children, now university students are seemingly making a satisfactory adjustment – the problem of relating in a new way to a parent who is no longer a 'father' has

been a challenge. For me the whole experience has been devastating – the loneliness and the feeling that others really do not understand is perhaps akin to that of the transsexual – but is not addressed very well by those dealing with the problem. The tendency for those in the helping role is to equate this situation to separation by death, or divorce for other reasons. The transsexual concerned goes on to a new life in hope of greater peace, happiness, fulfilment or whatever – the one who is left looks in bewilderment at a life shattered, love torn and loyalties divided – enough said.

However, in the light of this experience there can be no doubt that the real challenge lies in early recognition and treatment – before adult relationships are established. This is easy to say and yet because our relationship was good, our marriage good, and our children a delight, I am perhaps selfishly pleased that intervention did not become available sooner.

I am a practising physician. Many of my colleagues and those in the community are not aware of the situation and it is the expressed wish of my former spouse that it not be publicised. If you would kindly refrain from using my name it would be appreciated.

'ALIA DOUCI'

*(Name and address withheld
as requested)*