Sentinelle traces of an epidemic of acute gastroenteritis in France

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Data on morbidity concerning seven communicable diseases are collected on a continuous basis via videotex terminals (Minitels) from about 500 general practitioners (GPs)—ie, 1% of all the French GPs[1] (the Sentinelle system). A case of gastroenteritis is defined as a patient consulting a GP for acute diarrhoea that occurred within the past 15 days. An epidemic is detected when the national weekly incidence has been above the upper limit of the 95% confidence interval of the regression model applied to the non-epidemic data for 2 consecutive weeks.[2]

6189 cases of gastroenteritis were reported on Sentinelles between Dec 26, 1994, and March 5, 1995, when incidences were above the epidemic threshold. In four of the 22 regions of France, Sentinelle general practitioners reported more than 400 cases during the epidemic period: Ile-de-France (903), Bretagne (692), Rhône-Alpes (572), and Pays-de-Loire (534) (figure). We estimate that 2% of the French population has consulted their GPs for acute diarrhoea in January 1995. An infectious contact was reported in 50% of cases

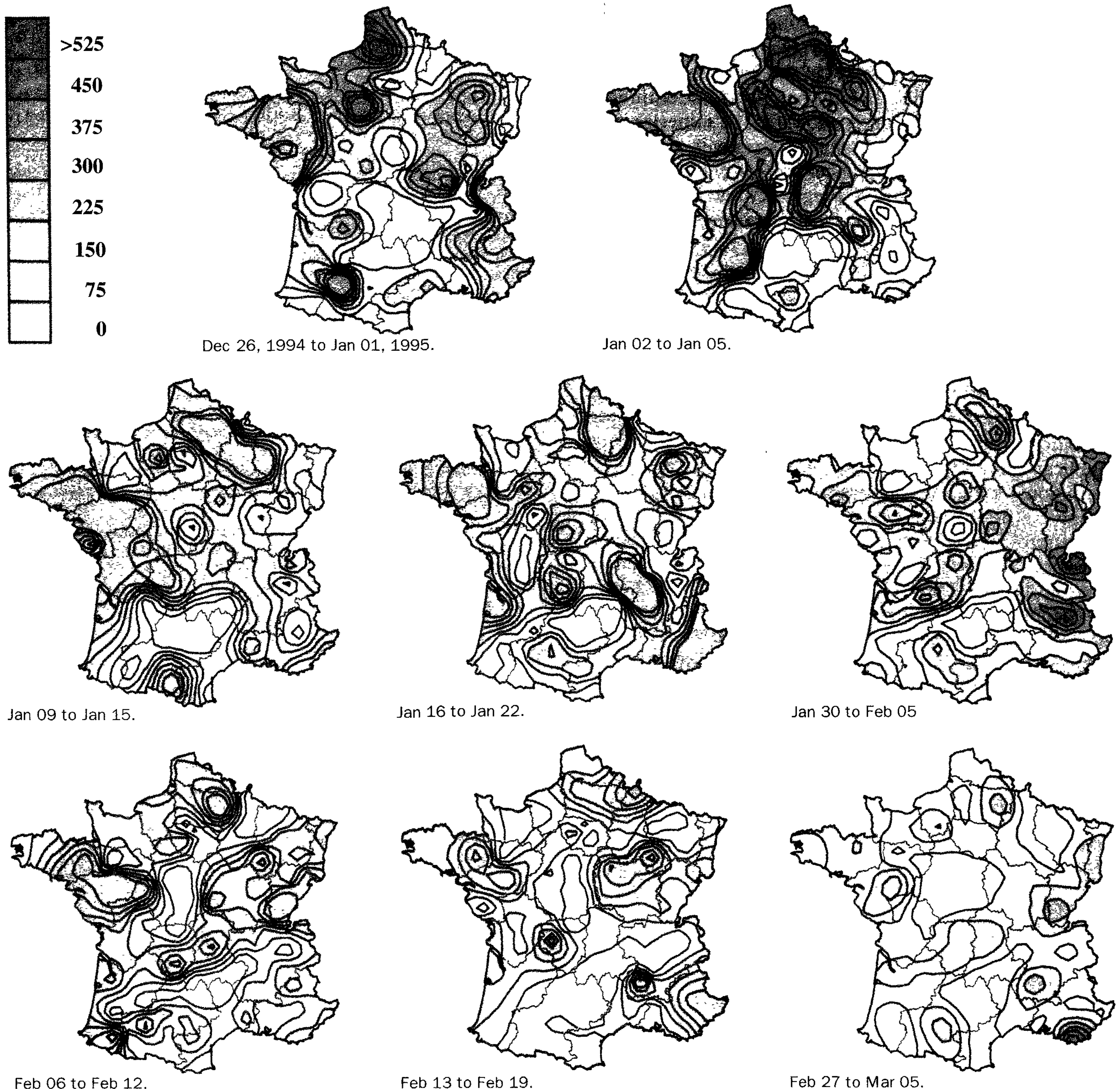

Figure: **Kriged maps of the incidence rates per 100 000 inhabitants for acute diarrhoea diagnosed by French Sentinelle GPs from Dec 26, 1994 to March 5, 1995.**

(versus 30% during the non-epidemic period), particularly within family, suggesting person-to-person transmission. Stool cultures are seldom done in general practice (only in 2% of cases) for common acute diarrhoea; however, cultures in 101 cases showed salmonella was significantly more rarely isolated (8% *vs* 28%) and rotavirus significantly more frequently (22% *vs* 7%) compared with the non-epidemic period.

We thank the Sentinelle GPs who collected these data. The Sentinelles network is a part of the French Communicable Diseases Network (FCDN), which is developed at INSERM U263 in collaboration with the Réseau National de Santé Publique (Public Health Network) and the Direction Générale de la Santé (Ministry of Health).

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Decisions and care at the end of life

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Successful public health and social policies and apparently inexorable medical advances are now compelling physicians and others who care for the elderly to confront clinical issues and ethical dilemmas that hardly existed fifty years ago. In North America and Europe more than 12% of the population are now over 65 years of age and all are facing decisions at the end of life which will affect their families and society.[1,2] Older people deserve to be cared for with respect and dignity.[3] They have more years of function and potential life fulfilment than any previous generation.[2,3] Indeed, so compelling is this positive image that some old people, when they become ill, question their bad luck or wonder what they did wrong. Despite the call for massive programmes of health promotion, many age-related conditions that cause disability (eg, Alzheimer's and Parkinson's diseases) and many malignancies and musculoskeletal syndromes have no identified pathophysiological process for which preventive measures are beneficial.[4] Although treatments for the underlying disease vary in efficacy , old people who become unwell will often benefit from interventions targeted at improving function even when no cure can be offered. Virtually all countries find that they cannot afford all that medicine has to offer and are looking at ways to decrease health care costs.[3,5] The elderly population, especially when life is drawing to a close, often become the focus of such efforts at cost control.[6,7]

Many issues arise at the end of life—where should one's last days be spent, consent to treatment, advance directives, aspects of clinical care such as resuscitation and palliation, and the controversies of euthanasia and assisted suicide—and this review cannot cover all of them in detail.

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The ties that bind

The modern family is mobile and dispersed in many western countries, especially the USA and Canada. On retirement many people go to warmer climates while children move away from their parents and grandparents because of educational, work, and social opportunities. While family members remain well and independent this geographical separation is of limited consequence since visits and communication by telephone and letter remain possible. The impact on families of prolonged illness and disability can be profound because a son's or daughter's ties and obligations of kinship to parents may conflict with their responsibilities to their own families and their jobs.

Old people usually want to live independently for as long as they can and many struggle with their own financial and living arrangements and with how best to spend the rest of their lives. Governments are grappling with the same issues as expenditure on social services and residential care mounts. Many government-supported options seem costly and attempts are being made to transfer the expense to old people themselves and their families. Although attractive conceptually, community-based systems of care may not always be cheaper than comparable facility care, and much of the burden of so-called community care is borne by families, usually the women.[8,9]

When the level of care required or a lack of community support means that admission long-term to a nursing home or the like is unavoidable the important question for the family is how to ensure that the care provided will be of high quality. For government the challenge is to maintain sufficient places without embarrassing the agencies appointed to oversee standards. And for those who run such long-term care facilities the goal is to provide a standard of service that is both acceptable to their clients and affordable.[8]

Consent to treatment

During the past two decades there has been a major shift in the relation between doctor and patient. "The doctor proposes, the patient disposes" is an aphorism that accurately encapsulates a large body of bioethics