

letters to the editor

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Simple clinical score

Editor – The article validating the 'simple clinical score' by Subbe, Jishi and Hibbs (*Clin Med* Aug 2010 pp 352–7) was very interesting. However, I have a few questions relating to it:

- 1 There is no mention of missing data. Were there no missing data (either for predictive parameters or outcomes)? If so, the data collectors are to be congratulated as this is extremely unusual.
- 2 Would it be possible to confirm that the mortality data do not include any deaths that occurred after discharge?
- 3 The methods section states that 'the collected data were used to establish receiver operator characteristic curves'. However, I was not able to see any such curves in the article.
- 4 I may be out of date, but interobserver variability used to be described in terms of a kappa score. There is no mention of a kappa score for interobserver variability. Is this because kappa scores are now considered obsolete?

PETER GIBSON

Consultant physician

Department of Medicine for the Elderly

North Manchester General Hospital

Risk scoring for acute admissions

Editor – For older patients there may be a simpler and more relevant basis for assessing risk of death and another important adverse outcome – institutionalisation – than the simple clinical score described by Subbe and colleagues (*Clin Med* Aug 2010 pp 352–7). Functional status has been shown to be the most important predictor of outcome and length of stay in patients aged over 65.^{1,2}

Two series of 200 consecutive admissions, predominantly acute, under my care, were

assessed using the Rankin scale during the first week of admission. The presence of four acute illness markers – AIMS – (hypoxia, hypotension, hyper/hypothermia and depressed conscious level) on admission was noted, along with whether the admission was due to fracture, acquired neurological deficit or any geriatric giants – immobility, falls, confusion or incontinence – (FANGGs).³ Patients were followed till death, discharge or 90 days, at which time patients were regarded as institutionalised.

There were 122 men, mean age 80, and 278 women, mean age 85. Men were more likely to die than women (25% v 15%). Risk of death increased from zero with Rankin score 0–43% at score 5, and from 14% with no AIMS to 77% with two or more. The effect of AIMS was only seen at Rankin grades 4 or 5, at which the risks of death were doubled from 23 to 45%, and from 31 to 62% respectively. The risk of institutional care rose from 14% with no FANGGs to 31% with one and 56% with two or more but only among those with a Rankin score of 3 or more. Length of stay correlated with Rankin grade and the presence of FANGGs. All differences on univariate analysis were unlikely to be due to chance ($p < 0.05$, chi-squared test).

While these results were obtained from patients selected for geriatric care and under one consultant, they could be the basis of a simple case-mix system, based on functional status and modulated by sex and AIMS for mortality and FANGGs for risk of institutional care and length of stay. This should be explored in a different setting.

The study was approved by South Birmingham Local Ethics Committee.

EDMUND DUNSTAN

Consultant geriatrician

West Heath Hospital

Birmingham

References

- 1 Campbell SE, Seymour DG, Primrose WR *et al*. A systematic review of factors affecting outcome in older medical patients admitted to hospital. *Age Ageing* 2004;33:110–15.
- 2 Campbell SE, Seymour DG, Primrose WR *et al*. A multi-centre European study of factors affecting the discharge destination of older people admitted to hospital: analysis of in-hospital data from the ACMEplus project. *Age Ageing* 2005;34:467–75.
- 3 Dunstan EJ. Modified admission case-mix for the elderly. *Age Ageing* 2001;30:531–2.

In response

We would like to thank the editor for the opportunity to reply to the interest generated by our paper on benchmarking of acute admissions units. We would also like to use the opportunity to thank Dr J Kellett, who developed the simple clinical score (SCS), and generously advised us on this project and the preparation of the manuscript.

The comments made are extremely valid:

- 1 Data were collected prospectively on a daily basis, including weekends. We used two methods to achieve best possible data capture: the daily take lists used by admitting doctors on the acute medical unit and the hospital administration system. There is a chance that patients could have been admitted directly to general wards thus bypassing the take. We cannot adjust for this. Additionally we checked against weekly lists of patients who died from the patient administration system to make sure that no patient with fatal outcomes was missed. The patient administration system captures out-of-hospital death, though with a possible delay. We cannot account for deaths post-discharge that were not entered into this system, but believe that the number would be small.

- 2 There were missing values in several parameters, ie we found no temperature recorded in 66 patients, no oxygen saturations in 22 patients, no respiratory rate in 20 patients and no heart rate in two patients. We believe that these figures are small and unlikely to influence the result of our analysis.
- 3 We apologise for the omission of the receiver operator characteristic curve and kappa values: the area under the ROC curve was 0.80 for 30-day hospital mortality. Inter-rate variability showed kappa values of 0.56 for the SCS but values of 0.84 for identification of life-threatening illness and 0.76 for a score indicating very low risk and possible option of discharge.

We fully agree with Dr Dunstan in stressing the importance of functional status and its impact on institutionalisation and hospital length of stay. This is the reason why inability to stand and spending part of the day in bed (as a shortened World Health Organization score) proved to be so important in the analysis leading to the development of the SCS.

It is interesting to see that the Rankin score also appears to identify groups of patients with very low and very high mortality. The question would be whether this relationship is stable in different hospitals and whether it would be possible to translate the score into a triage tool. We believe that the key problem for triage of patients at risk of institutionalisation is to find a tool that is fast and specific enough to allow therapeutic interventions. In order to describe frailty and lack of functional reserve a fair number of tools have been advocated.^{1,2} The challenge that remains is to translate them into operational algorithms with positive and negative predictive values, which can support clinical decision-making.

CP SUBBE

*Consultant in acute and intensive care medicine
Wrexham Maelor Hospital, Wrexham*

F JISHI

*Consultant in acute medicine and cardiology
Wrexham Maelor Hospital, Wrexham*

RAB HIBBS

*Director
Integral Business Support, Wrexham*

References

- 1 Rolfson DB, Majumdar SR, Tsuyuki RT, Tahir A, Rockwood K. Validity and reliability of the Edmonton Frail Scale. *Age Aging* 2006;35:526–8.
- 2 Rockwood K, Song X, MacKnight C *et al*. A global clinical measure of fitness and frailty in elderly people. *CMAJ* 2005;173:489–95.

Assisted suicide

Editor – Randall and Downie argue unconvincingly that involvement in assisted suicide (AS) is incompatible with being a doctor (*Clin Med* Aug 2010 pp 323–5). A clause, totally out of context, from an ancient – almost never sworn – oath is of little relevance to modern medicine. The General Medical Council (GMC) decides what is appropriate for doctors in their duties to the individual and to society. No GMC comment on AS is needed while AS is illegal but it is unlikely it will exclude doctors specifically if society decides that AS is permissible. This would be in line with its guidelines on end-of-life care and on the withdrawing/withholding of life-sustaining treatments (passive euthanasia). It would also be in line with past medical tradition as regards its use of ‘double effect’ – a use now considered misuse – so widely accepted that it was argued that law change was unnecessary as doctors already had what was needed to control symptoms if other treatments failed. AS may well have to involve a different medical team but doctors are involved already if and when dying patients wish to discuss it as a possible option or wish for an honest prognosis. In the circumstances envisaged it is not an ‘adverse outcome’ any more than switching off a ventilator when appropriate. Doctors will be crucial in ensuring that the patient really is making an informed choice – very different from being just a ‘supplier of goods’. It is questionable how far doctors need to be involved in the last stages of the AS pathway, perhaps apart from the prescription. In Oregon, doctors are rarely present at the time of ingestion. To exclude doctors specifically could be cruel: hopefully many will accept an ongoing obligation to the patient, who might even have second thoughts. Finally, by opting out on principle, we would diminish our relevance

as a profession in the debate – regrettable, even though the present Royal College of Physicians stance differs from my own views as a member of Dignity in Dying.

SIMON KENWRIGHT

Retired physician

In response

In Dr Kenwright’s letter he attributes claims to us which we did not make; (strangely) he agrees with us on our points of main substance; he totally misunderstands GMC and British Medical Association (BMA) views on withholding and withdrawing life-prolonging treatment.

Firstly, we did not say that doctors either do or ought to subscribe to the Hippocratic oath, but only that the oath is the beginning of a long tradition, developed at the present time by the GMC and BMA, which defines what it is to be a doctor or sets limits to the role of the doctor. Secondly, he makes the same point himself when he says, ‘The GMC decides what is appropriate for doctors in their duties...[and later] It is questionable how far doctors need to be involved in the last stages of the AS pathway...’. Dr Kenwright has in fact stated with approval our main points. Thirdly, the withholding or withdrawing of treatment because it is not providing an overall health benefit is permitted in law and BMA/GMC professional guidance, and death when it occurs as the outcome of the illness does not constitute an ‘adverse outcome’ of treatment; it certainly does not constitute euthanasia (the term ‘passive euthanasia’ has been dropped from professional discussions because it is misleading). As for the doctrine of ‘double effect’, it notes that most treatments have good and bad effects. The doctor must aim at the good effect (such as relieving pain) while being aware that the bad effect may (rarely) shorten life. The doctrine in no way sanctions the intent to kill.

Finally, while doctors routinely discuss diagnosis and prognosis with their patients, including those approaching the ends of their lives, we think (contrary to Dr Kenwright) that if AS were to be legalised, doctors would be ill-advised to be involved