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.

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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

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in the seeking of consent for AS. After Shipman, the media, and perhaps some families, would be all-too-ready to claim that a doctor exerted undue pressure on a patient. Whatever is to be argued for or against AS (and we were neutral on this) there is no logic in calling it a 'health benefit', and if doctors concern themselves with matters other than health benefits they will fall under suspicion.

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Perceptions of heart failure

Editor – I read with interest Banerjee's paper about patients' understanding and perceptions of the diagnosis of heart failure (*Clin Med* Aug 2010 pp 339–43). Much is often made of the poor prognosis of heart failure when compared with various malignancies. However, it is only at the level of prognosis that people seem to draw comparisons. Why?

Patients understand that malignancy is serious and as such patients are aware that treatment is necessary if life is to be prolonged. The same cannot necessarily be said of heart failure patients. In an audit performed in a GP's practice of patients with heart failure managed in primary care, I found that only a third of patients were on maximum tolerated doses of ace inhibitor and betablocker, ie being treated as aggressively as possible. It is hard to imagine only a third of cancer sufferers getting full doses of chemotherapeutic agents. Furthermore, when the rationale for repeated appointments to increase the doses of these medications was explained to patients, every patient attended for further uptitration of their medications.

If we do not tell patients negative prognostic information, then how can we expect them to engage with multiple appointments and blood tests, and comply with new medication regimens which may not make them feel any better in the short term but will offer them advantages in mortality and morbidity?

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The European Working Time Directive and training

Editor – Goddard presented important preliminary findings in his editorial on the impact of the European Working Time Directive on training (*Clin Med* Aug 2010 pp 317–18). However, his conclusion that conversion to a 56-hour working week has not significantly impacted on the quality of training of physicians is unsupported by data. Admittedly, he concedes that the measurement of such impact is difficult due to the lack of validated quality measures of training. While the table he presented may not demonstrate a statistical difference in numbers of procedures performed by trainees between the two periods assessed (1998–2002 and 2003–7), procedural competency in the 'craft medical specialties' is nevertheless influenced by absolute numbers of procedures undertaken. Of the procedures listed in the table, only trainee-performed angiography and echocardiography increased in numbers between the two periods. This may be a cardiology-specific characteristic; indeed, in the same article, Goddard comments on the longer hours that cardiology specialist registrars (SpRs) work in comparison to another specialty. Perhaps something useful may be learned from our cardiology trainers in this regard. With respect to the numbers of bronchoscopies performed pre- and post-2003, while the comparison may not be p-value significant, it is undeniable that a mean difference of over 60 procedures performed by the end of training is likely to be qualitatively significant in distinguishing a skilled and procedurally-confident late-stage SpR or new consultant from a merely competent one.

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In response

I agree with Dr Chua's comments. The data presented were based on a survey of consultants completing their training in the past 10 years and as such were subject to recall bias. Usually, unless detailed records have been kept, individuals over-estimate how many procedures they have done. Since that study we have started an annual survey of trainees obtaining a certificate of completion of training in the previous 12 months. This survey includes collecting procedural numbers during training. Data from the 2009 survey show that numbers have fallen in all the procedures compared with the data I presented. The numbers for colonoscopy, endoscopic retrograde cholangiopancreatography, angiography, echocardiography, chest drains and bronchoscopy were 607, 186, 907, 780, 52 and 68 respectively. These data were not available when I wrote the editorial but certainly give good weight to the concerns many consultants, including myself, have about the quality and quantity of training in a 48-hour week.

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Master of Science in medical leadership

Editor – I read with interest the article on the varied academic approaches to medical leadership (*Clin Med* Oct 2010 pp 477–9). I was surprised, however, that the authors failed to include a reference to Kent, Surrey and Sussex deanery's clinical leadership fellowship which is now in its second year and has the advantage that it combines practical management experience for a cohort of registrars in hospital trusts with a work-based masters at Brighton Business School in clinical leadership and healthcare management. There is also the benefit that this is a fully funded/salaried position which none of the other courses appear to be. If the desire is for younger physicians to be involved and experienced in management and lead on transformational change projects then this format perhaps represents

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