

severe depression meant the person was by definition incapable; 38% thought that a recent assessment of incapacity meant the person was by definition incapable, but this is wrong as a capacity assessment is only valid for a specific question at a specific point in time. No completed questionnaire had all the answers correct.

With the full implementation of the Mental Capacity Act 2005 fast approaching this shows a great need for teaching and guidance on capacity.

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Napoleon's doctors

Editor – I read the book review on *Napoleon's Doctors* with interest. I imagine that members of my Society would be happy to claim the victory at Waterloo for Admiral Lord Nelson and although he had been dead for 10 years, perhaps his influence came from above. The two great men, Nelson and Wellington, met only once, fleetingly, at the Colonial Office on 12 September 1805. Thirty years later, by now Prime Minister, Wellington said 'I don't know that I ever had a conversation that interested me more'.

JK WOOD
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While grateful for the suggestion of divine intervention it was more likely a failure on the part of the Editor to spot this error. Napoleon was of course defeated at Waterloo by the Duke of Wellington (and not by Nelson who died in 1805, ten years before the battle).

Editor

Myths of ageing

Editor – Mulley's lecture (*Clin Med* January/February 2007 pp 68–72) is very thought-provoking and raises a number of important issues concerning the negative stereotyping of older people. There is, however, another type of false reasoning about the elderly which is widespread, namely the notion that it is unnecessary to even consider a patient's age when making decisions about their treatment: some older people

(and their relatives) are hopelessly unrealistic about the likely benefits of treatment, especially advanced, technologically intensive treatment, in people of advanced age. I recently had a conversation with the next of kin of a patient who was in his mid-80s. He had chronic renal failure and aortic stenosis and was not responding to treatment for pneumonia. Despite the patient's history and poor clinical condition I found it very difficult to persuade the relative that continuation of active treatment was unlikely to be of benefit.

Whether we like it or not, advancing age is a proxy for progressive loss of functional reserve in vital organs, and usually in several organs rather than just one. If one adds to this the stress of an acute illness (pneumonia, myocardial infarction or whatever) then it is no surprise if things do not go well. The able physician, it seems to me, is the one who can give proper weight to the patient's age in the overall assessment of their condition and medical prognosis. Mulley has, rightly, reminded us of the serious dangers of jumping to negative conclusions when looking after older people. I would venture to ask him also to be aware of the risk of exposing doctors to criticism (especially from patients' families) for simply attempting to make a balanced judgement about the care of older patients.

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Modern management of atrial fibrillation

Editor – The reluctance to anticoagulate elderly patients with atrial fibrillation (AF) (*Clin Med* January/February 2007 pp 28–34), even in the absence of contraindications,¹ might, at least in part, be attributable to the fear that, in the event of treatment-related haemorrhagic complications, those patients might, by virtue of age alone, be denied life-saving interventional treatment. Already, it is acknowledged that as many as 46–48% of doctors, ranging from primary care to secondary care, would be prepared to deny patients aged >65 treatment that they would otherwise offer to their younger counterparts.² These attitudes are exemplified by the proposal

(unsupported by any prospective study) that, following traumatic intracranial haematoma (typically a subdural haematoma resulting from 'a tumble down stairs'³) 'there is little point in active treatment over the age of 65 for those who remain in coma (Glasgow coma scale of 8 or less) for more than 6 h...'³ Furthermore, patients aged 65 or more with either extradural or acute subdural haematoma are less likely to be transferred to neurosurgical care than their younger counterparts.⁴ With regard to upper gastrointestinal haemorrhage, although an audit of patients with bleeding peptic ulcer documented a reduction in mortality if the over 60s were operated on early,⁵ this does not necessarily translate into a more proactively interventional stance for the over 65s and over 75s with this complication, given the recent findings on doctors' ageist attitudes.² In the final analysis, it is our uncertainty about the attitudes of our colleagues which generates a reluctance to prescribe anticoagulants to the over 65s.

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In response

It is with interest that we read comments raising the possibility that the ageist attitudes of physicians is the primary factor responsible for the under-prescribing of anticoagulation in those at greatest risk of

stroke from atrial fibrillation (AF).¹ Although ageism may certainly be relevant, the evidence would suggest that the underlying reasons are far more complex.

The overwhelming evidence in favour of oral anticoagulation from clinical trials is testament to the importance of this therapy as part of a stroke prevention strategy in high-risk patients with AF. Yet despite this, such therapy remains underutilised.² Naturally, the primary concern is of significant haemorrhage, but, lifestyle restrictions (eg alcohol), compliance, psycho-social implications, and the need to attend regular therapeutic monitoring are all factors in the decision on whether or not to anticoagulate.³ Furthermore, up to 40% of patients express the preference not to receive anticoagulation.⁴ Unfortunately each of these factors is more common in the elderly who similarly are also likely to have one or more other stroke risk factors such as prior stroke, hypertension, diabetes mellitus and congestive cardiac failure – reinforcing the need for adequate thromboprophylaxis in this patient group.⁵ In addition, many physicians argue that elderly patients would not be able to manage the complexities of changes in dosage as is often required with warfarin.

How can things improve? It is important to remember that stroke can be a devastating event and many patients perceive a moderate-severe stroke to be a fate worse than death.⁶ This is quite understandable, given that the outcome for stroke in AF is particularly poor with greater morbidity, mortality and fewer discharges to the patient's own home.⁷ Thus an accurate assessment of stroke risk is mandatory. This process is aided by the various risk stratification tools and one of these is included as part of the current National Institute for Health and Clinical Excellence (NICE) guideline on the management of AF.⁸

Self-monitoring of anticoagulation may be helpful, particularly in the elderly (≥ 65 years) where this has been demonstrated to enhance the time spent within the therapeutic international normalised ratio range compared to clinic monitoring.⁹

Of paramount importance, however, is patient involvement in the decision making process. Due care should be paid to ensuring the patient understands both the

risk of stroke and the risk of bleeding as a consequence of anticoagulation. Only then can an informed decision be made.

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Knowledge-based assessments: maintaining rigour in standard setting processes.

Editor – The editorial by Booth (*Clin Med* January/February 2007 pp 9–11) reviews the recent Joint Committee on Higher Medical Training pilot project on knowledge-based assessments for specialist registrars (SpRs).

The data on cardiology in particular

provide insight into complexities involved in assessment processes and resultant outcomes. The cardiology cohort totalled 303 participants: 12 consultants and others of SpR-level grades. Booth comments that 'the pass mark for cardiology was clearly too high, probably because the standard setting process was not followed rigorously and was combined with question setting, editing and selection processes.' This raises some concern, as one essential element of standard setting processes is that they maintain sufficient rigour, and are as transparent and as defensible as possible,¹ especially with regards to high-stakes examinations that involve making summative decisions on performances, and have outcomes defined in terms of pass/fail decisions.^{1,2}

Booth succinctly describes the Angoff process,³ to which certain modifications have been made since its original description three decades ago. It is probably the most common method used for setting standards in assessments of the health profession.^{1,2} The process is characterised by being: test-centred (in comparison to some other methods which may be examinee-centred), criterion-referenced (rather than norm-referenced), reliant on the judgements of experts/panellists, and requiring an understanding of the characteristics of the 'just-passing'/'borderline' candidates. As Booth stresses, defining the 'just-passing' candidate is difficult, even for experienced and expert panellists who have put considerable effort and time into the process. Each question for the intended examination undergoes stringent evaluation.

The fact that the overall pass rate was 4.8% for the entire cardiology cohort (with a pass rate of 8% of the participating consultants), raises possibilities that: (1) candidates truly performed badly in the pilot, (2) there was difficulty defining the 'just-passing' candidate for each question and/or for the whole examination, or (3) that the standard was set too high and therefore unrealistic (the pass mark was set at 83% for the 50 test items).

One modification to the Angoff technique that can aid, but not eliminate the difficulty of defining the 'just-passing' candidate, is that following the initial stages of pass mark determinations, panellists are provided with actual performance data