letters
TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and sent by email to: Clinicalmedicine@rcplondon.ac.uk

Editorial: 'Thousands starving in UK hospitals'; letter 1

Editor – Robert Allan's editorial about malnutrition in hospital (*Clin Med* October 2007 pp 429) gives the impression that little can be done about it, which goes against national and international policies eg from the Council of Europe,[1] National Institute for Health and Clinical Excellence,[2] and NHS Quality Improvement Scotland,[3] and against the clinical evidence (detailed below). It also trivialises the problem by stating that special interests groups aim to raise their profile by calling the public's attention to the occasional patient whose malnutrition has been overlooked. The Royal College of Physicians' own report indicates that malnutrition is a major problem affecting up to 40% of patients in hospital,[4] confirmed by a recent review[5] and the UK Nutrition Screening Week. There is also considerable concern that the majority of malnutrition in hospitals is unrecognised and inadequately treated (not just in the occasional patient),[6,7] and this has helped drive national policies, including the recent NHS report, *Improving nutritional care*.[8] Malnutrition remains a major clinical and public health problem with costs comparable to obesity and overweight.[9]

The idea that there is little opportunity for nutritional interventions because of short length of stay is also rather simplistic for at least three reasons. First, identification of malnutrition in hospital is important because it can initiate treatment that continues in the community after hospital discharge. Second, the length of hospital stay increases with age, the presence of malnutrition, and complications associated with malnutrition. This means that the time available for treating malnutrition in hospitalised older individuals could be weeks rather than days. Third, treatment provided over a short period of time can make a large difference to outcome. Inappropriate feeding can result in complications and sudden death from the re-feeding syndrome. The benefits of nutritional support should not just be measured in terms of changes in body composition, which may take considerable time to occur. Appropriate nutritional support and good metabolic control during key periods of an illness in hospital can not only improve the well-being and experience of patients during their hospital journey, but also favourably affect clinically important outcome measures, including mortality, complications and length of hospital stay.[5,10]

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References

1 Council of Europe, Committee of Ministers. Resolution ResAP (2003)3 on food and nutritional care in hospitals. November 2003. https://wcd.coe.int/ViewDoc.jsp?id=85747&Site=CM&BackColorInternet=9999CC&BackColorIntranet=FFBB55&BackColorLogged=FFAC75
2 National Institute for Health and Clinical Excellence. *Nutrition support in adults.* Clinical Guideline 32. London: NICE, 2006.
3 NHS Quality Improvement Scotland. *Food, fluid and nutritional care.* Edinburgh: NHS QIS, 2003.
4 Royal College of Physicians. *Nutrition and patients: a doctor's responsibility.* A report of a working party of the Royal College of Physicians. London: RCP, 2002.
5 Stratton RJ, Elia M. A review of reviews: a new look at the evidence for oral nutritional supplements in clinical practice. *Clin Nutr Suppl* 2007;2:5–23.
6 McWhirter JP, Pennington CR. A comparison between oral and nasogastric nutritional supplements in malnourished patients. *Nutrition* 1996;12:502–6.
7 Elia M. The 'MUST' report. *Nutritional screening for adults: a multidisciplinary responsibility. Development and use of the 'Malnutrition Universal Screening Tool' ('MUST') for adults.* A report by the Malnutrition Advisory Group of the British Association for Parenteral and Enteral Nutrition. London: BAPEN, 2003:127.
8 Department of Health. *Improving nutritional care.* London: DH, 2007:80.
9 Elia M, Stratton R, Russell C, Green C, Pang F. *The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults.* A report by the Health Economic Group of the British Association for Parenteral and Enteral Nutrition (BAPEN). London: BAPEN, 2005.
10 Stratton RJ, Green CJ, Elia M. *Disease-related malnutrition. An evidence-based approach to treatment.* Oxford: CABI Publishing, 2003.

Editorial: 'Thousands starving in UK hospitals'; letter 2

Editor – The recent editorial by Robert Allan is dismissive of the importance of undernutrition in UK hospitals and of those who strive to improve the nutritional status of their patients. They are described as 'belonging to specialist interest groups and keen to raise their own profile by calling the public's attention to the occasional patient whose malnutrition has been overlooked'.

It is difficult to comprehend what motivation might have lead to this negative and damaging editorial. It flies in the face of evidence, national guidelines,[1] and government policies. Furthermore, the Royal College of Physicians (RCP) and its recent presidents have been particularly supportive of malnutrition as an under-recognised and under-treated problem with a

great impact on health in hospital and the community. Much can be done in hospital to establish the much needed continuity of care between settings.

The RCP Nutrition Committee has focused the efforts of the College (itself a special interest group?) to improve standards of care and the training required to achieve this. The RCP publication *Nutrition and patients: a doctor's responsibility* encapsulates the ethos required of modern clinicians.[2] While it is true that much disease-related malnutrition can not be readily reversed, to suggest that only a minority of hospital patients need nutritional support is to fly in the face of the evidence. Encouragement of such negative attitudes leads to the classic 'we see no ships' response from clinicians who do not even regard weighing their patients as a useful activity. It is correct that we should be concerned about substandard hospital food, but many patients require artificial nutritional support to survive. In 2006, 36,500 adults and children received artificial nutritional in the UK community.[3] Most were introduced to these treatments as inpatients by clinicians working in multidisciplinary teams. In addition, as many as 15% of hospitalised patients receive oral nutritional supplements (supported by an evidence base), further emphasising that malnutrition is common in hospital.

The recent Nutrition Screening Week (supported by special interest groups such as the British Association for Parenteral and Enteral Nutrition, British Dietetic Association, Royal College of Nursing, National Patient Safety Agency, Department of Health, the governments in England and Scotland, the Welsh Assembly and Chief Nursing Officer in Northern Ireland) identified that 28% of 9,722 inpatients screened over three days in acute hospitals were at risk of malnutrition.[4] This figure rises to 38% in those aged over 60 – hardly an insignificant minority.

Nutrition is a basic human right. It is also the duty of all modern practising physicians to take a 'special interest' in the nutrition of their patients.

BARRY JONES
Chair, Nutrition Committee
Royal College of Physicians

References

1 Royal College of Physicians. *Nutrition and patients: a doctor's responsibility*. London: RCP, 2002.
2 National Institute of Health and Clinical Excellence. *Nutrition support in adults*. London: NICE, 2006.
3 Jones BJM. Annual BANS report, 2007. *Artificial nutrition support in the UK, 2000–2006*. London: BAPEN, 2007.
4 British Association for Parenteral and Enteral Nutrition. Nutrition Screening Week. www.bapen.org.uk/pdfs/nsw/nsw_07_factsheet.pdf

Editor's response to Elia and Jones

I apologise if my editorial gave the erroneous impression that I was 'dismissive of the importance of under nutrition in hospital, that little could be done about it and that it trivialised the problem'. The comment concerning special interest groups was directed not at societies like your own but, as suggested by the dramatic title 'Thousands starving in UK hospitals', to press reports and the tendency to trivialise the issue. This should have been made more explicit. The main purpose of the editorial, which has been obscured by this misunderstanding, was to promote improvement in hospital catering which has lagged well behind improvements in clinical care. This is an improvement that we would all support. To clarify the situation for our readers and redress the balance, we will invite the correspondents to contribute an editorial concerned with the analysis of the results from their recent important Nutrition Screening Week survey.

ROBERT ALLAN
Editor, Clinical Medicine

College comment on 'Thousands starving in UK hospitals'

I thought it might be helpful following the correspondence about the recent editorial about malnutrition in hospital if I stated the College's position. This is set out in detail in a College publication dated 2002 entitled *Nutrition and patients: a doctor's responsibility.* The College accepts that as many as 40% of patients are undernourished on admission to hospital and 2/3 of all hospital inpatients lose weight during their stay. Malnutrition impairs organ function and recovery from illness and nutritional support can improve nutritional state and reduce morbidity. However, as Professor Allan's editorial points out, nutritional support during a short hospital stay is usually not sufficient for patients who are undernourished and it is important that integrated nutritional care is continued into the community. Moreover, there are some patients for whom invasive procedures with risk to deliver artificial nutrition are inappropriate.

The College is committed to improving the nutritional care of patients in hospital and outside and encourages Fellows, Members and trainees to play a leading role in seeing that this is achieved. It believes that this is best achieved by a medically led multidisciplinary nutrition support team, both in hospital and outside. A nutrition advisory group should similarly exist in every hospital and the existence and activity of these should be part of the Healthcare Commission's Health Watch.

RODNEY BURNHAM
Registrar, Royal College of Physicians

Complexity of treatment decisions with older patients

Editor – The article by Martin and colleagues is most welcome, particularly in the light of the Mental Capacity Act 2007 (*Clin Med* October 2007 pp 505–8). As doctors receiving acutely ill, but obviously frail and elderly patients on a daily basis, my colleagues and I face a situation where there is a complete lack of any prior thought as to how the person should be managed in the event of them becoming ill. In Martin *et al*'s first case vignette, one has to ask why the patient's regular carers did not call her general practitioner (GP) rather than 'phoning for an ambulance'. If they had done this and if an appropriate conversation had taken place between the GP and the patient's family then the assault on the patient with intravenous (iv) drips and nasogastric tubes might have been avoided.

The situation is often even worse with people admitted from nursing homes: by definition such patients are dependent and somewhat frail, yet nursing homes do not seem to ask the question: 'if you/your mother/your husband becomes ill, how