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LETTERS

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TURNING OLD AGE INTO A DISEASE?

Older people are undertreated as much as they are overtreated

As a geriatrician, I see daily the iatrogenic effects of overtreatment of older patients that is partly driven by a box ticking, target oriented culture.[1] People are taking drugs they no longer need or may never have needed or that haven't been meaningfully reviewed for some time, despite the quality and outcomes framework.

However, common, serious, and debilitating conditions largely affecting older people tend to be under-recognised and poorly managed while services and research tend to be underfunded and education of professionals inadequate. In hospitals older patients with legitimate and treatable medical problems (often manifesting with loss of physical function or impaired cognition) are written off as "social" or "acopia."

Although ageing should not be routinely medicalised, danger lies in having treatable problems in older people "socialised." Patients over 65 already account for around 70% of bed days in NHS hospitals, but priorities have yet to catch up with the fact that frailty, ageing, and long term conditions are core to health. Many patients don't present in "textbook" fashion, and much of medicine is about maintenance or palliation rather than cure, about the commonplace not the rare and diagnostically challenging, and about low tech rather than high tech interventions. So we have the bizarre paradox of general practitioners being given incentives to treat, say, hypertension or cardiac failure aggressively, while conditions such as incontinence, osteoporosis, dementia, delirium, and falls are far down the pecking order.

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Competing interests: None declared.

1 Oliver M. Let's not turn elderly people into patients. *BMJ* 2009;338:b873. (3 March.)

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Better evidence is the answer

Although guidelines are inappropriately applied to frail older people,[1] ignoring disease or its risk factors in older people is not a useful response. The high rates of illness and consequent devastating effects on physical and psychosocial function borne by many older people suggest that there may be much to gain by appropriate intervention.[2] Rather than simply railing against the medicalisation of old age, it may be more productive to reassess the type of evidence that should underpin treatment recommendations.

Older people are often not studied in clinical trials,[3] and common trial outcomes such as death and admission are relevant only to some of them. Data on end points that are highly relevant to a lot of them, such as falls, cognition, physical function, and quality of life, are lacking from many trial protocols and reports.

That guidelines are promoted uncritically outside the evidence on which they are based is not surprising. Wise healthcare practitioners already resist such extrapolation. High quality trials are needed that include frail older people and examine relevant benefits and harms. Only then will we know whether efforts to prevent and treat illness in older people provide a net overall benefit.

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Competing interests: MDW performs clinical trials in frail older people that use a range of patient centred outcomes.

1 Oliver M. Let's not turn elderly people into patients. *BMJ* 2009;338:b873. (3 March.)
2 Kamper AM, Stott DJ, Hyland M, Murray HM, Ford I, PROSPER Study Group. Predictors of functional decline in elderly people with vascular risk factors or disease. *Age Ageing* 2005;34:450-5.
3 Masoudi FA, Havranek EP, Wolfe P, Gross CP, Rathore SS, Steiner JF, et al. Most hospitalized older persons do not meet the enrolment criteria for clinical trials in heart failure. *Am Heart J* 2003;146:250-7.

Cite this as: *BMJ* 2009;338:b1199

On disobeying NICE guidance

I agree with Oliver about guidelines.[1] More importantly, so does the National Institute for Health and Clinical Excellence (NICE):

> The institute has always indicated that health professionals, when exercising their clinical judgment, should take its guidance fully into account; but that it does not override their responsibility for making appropriate decisions in the circumstances of the individual patient. This principle is important because even the best clinical guideline is unlikely to be able to accommodate more than around 80% of patients for whom it has been developed.[2]

More recently, however, Baroness Young has reportedly indicated a willingness to prosecute doctors who do not follow NICE guidance. The use of criminal law to enforce guidelines is a remarkable proposal. Other sanctions under consideration include suspension of doctors and closure of their practices.[3]

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Competing interests: PG arranged to leave general practice in 2003, the day after voting no to the GP contract.

1 Oliver M. Let's not turn elderly people into patients. *BMJ* 2009;338:b873. (3 March.)
2 National Institute for Clinical Excellence. *Response to the report of the Bristol Royal Infirmary Inquiry*. London: NICE, 2001:8. www.nice.org.uk/niceMedia/pdf/bristolreportresponsefinal.pdf
3 Praities N. Threat of legal action if GPs fail to follow NICE. *Pulse* 2008, 11 Dec. www.pulsetoday.co.uk/story.asp?sectioncode=23&storycode=4121395

Cite this as: *BMJ* 2009;338:b1198

"PUBLIC-RESEARCHER PARTNERSHIP"

Realities in accessing records

As a paediatrician, I agree that current trends in regulation risk impeding or even preventing important research that patients and their parents want done.[1] People who have (or whose children have) experienced acute and chronic illnesses usually enthusiastically support (appropriately vetted, good quality) research and, indeed, often donate generously to the charities that fund much of the best UK research. If you ask them whether they want protection from the intrusion of their (or their child's) records being screened for eligibility for a study, the stock response is: "Don't be daft, get on with it!"

In addition, clinical research nurses who identify suitable potential subjects for studies are generally recruited, or on secondment, from the clinical teams that manage the children they are screening. They have contracts with the same NHS trusts and are bound by the same codes of professional conduct as the staff delivering day to day care. To exclude them from routine access to a child's paper or electronic records makes no more sense than forbidding a nurse or doctor from the next door ward from doing the same thing and flies in the face of the spirit of

professionalism, teamwork, and cooperation that characterises the NHS.

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Competing interests: AF is a clinical researcher and works for the University of Bristol and University Hospitals Bristol NHS Foundation Trust.

1 Cooper L. Charities call for "public-researcher partnership" in sharing electronic patient data. *BMJ* 2009;338:b856. (27 February.)

Cite this as: *BMJ* 2009;338:b1196

AID MONEY WASTED, SAYS OXFAM

Oxfam must shed its ideological bias to be taken seriously

Oxfam has called for better information on the role of the private sector in health care in developing countries, while simultaneously demanding that the World Bank and others stop supporting programmes or policies that would work with the private sector.[1] Oxfam bases this call on data that are thin, selective, and distorted.

Oxfam notes on the basis of an unpublished study that in 44 middle and low income countries the higher the private sector participation in primary health care the higher the overall level of exclusion from treatment and care (M Koivusalo, M Mackintosh, UNRISD international conference on commercialisation of health care, 2004).

An alternative interpretation is that poor government provision has led to higher rates of private sector provision. In other words, it is because governments do little that private services make up a larger percentage of all care.

The data do not indicate causality, but Oxfam does not acknowledge this. Citing its "analysis of data from demographic and health surveys in 15 sub-Saharan Africa countries with comparable data categories for private providers,"[2] Oxfam shows that only 3% of all patients visiting the private sector go to doctors and that 40% of private provision in Africa is "just small shops selling drugs of unknown quality."

However, the analysis includes 21 countries, the more complete information showing that shops represent 29% of the source of care and that 11% of patients in the poorest fifth were seen by a doctor. An additional 24% were treated in a "private facility," which, as Oxfam must have known, means a multiprovider facility where there is a doctor plus other providers. So 37% of patients were seen by a doctor or better. Oxfam has distorted the data tenfold.

Oxfam should put its ideological bias aside so that its voice can be appreciated in the debate on the role of the private sector in health systems. Also, if "money would be better invested in health services provided by governments," then Oxfam, a private organisation, should give back the money it receives from the British government to provide services.

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On behalf of Richard Feachem, Neelam Sekhri Feachem, Tracey Perez Koehlmoos, Heather Kinlaw, and Richard Smith

Competing interests: Full details are given in the rapid response www.bmj.com/cgi/eletters/338/feb16_2/b667#210071.

1 Mayor S. Aid money is wasted on private healthcare programmes in poor countries, says Oxfam. *BMJ* 2009;338:b667. (16 February.)
2 Marek T, O'Farrell C, Yamamoto C, Zable I. *Trends and opportunities in public-private partnerships to improve health service delivery*. Washington, DC: World Bank, 2005. (Africa region human development series.)

Cite this as: *BMJ* 2009;338:b1202

RESTING HEART RATE AS PREDICTOR

What about absolute risks?

It is a fundamental principle in public health that you should never quote a relative risk without also giving the absolute risk.[1] Failure to follow this simple precept results in the weekly health scares that engage the popular press, when an increased relative risk is taken as a threat to the individual.

Hsia et al flagrantly ignore this principle when they claim that "resting heart rate independently predicts myocardial infarction or coronary death in women."[2] They base this assertion on a hazard ratio of 1.26 (95% confidence interval 1.11 to 1.42) for these events in women above the top quintile for heart rate compared with women below the bottom. They do not quote absolute risks. Using some simplifying assumptions (equating hazard rate to relative risk, assuming total events in lower fifth and upper fifth is proportional to the number of subjects in these groups), I estimated the absolute risk of myocardial infarction or coronary death in the 7.8 years of follow up to be 0.0194 for those in the top fifth and 0.0154 for those in the bottom fifth. This equates to an absolute difference of 0.4%, or a number needed to treat to harm (NNTH) of 250 (167 to 539).

In other words, in those deemed to be at a higher risk, out of 250 women only one extra woman would have an event in about 8 years. This is not what the public think of as a predictor. Those in the top fifth should not be unduly concerned.

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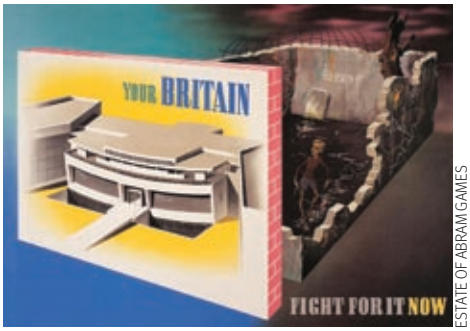
Competing interests: None declared.

1 Campbell MJ, Machin D, Walters SJ. *Medical statistics: a textbook for the health sciences*. 4th ed. Chichester: John Wiley, 2007:24.
2 Hsia J, Larson JC, Ockene JK, Sarto GE, Allison MA, Hendrix SL, et al. Resting heart rate as a low tech predictor of coronary events in women: prospective cohort study. *BMJ* 2009;338:b219. (3 February.)

Cite this as: *BMJ* 2009;338:b1197

RESTRUCTURING THE NHS

Finsbury Health Centre's demise



ESTATE OF ABRAM GAMES

Heath gets to the kernel of the problem of the restructuring of the NHS.[1] The indecent haste to impose polyclinics in every primary care trust (PCT), ignoring the perfectly good services that already exist as in the historic Finsbury Health Centre, makes a mockery of the principles that Ara Darzi stated would guide the implementation of his proposals: locally driven, clinically led, and no closures until alternatives are ready.

I addressed the meeting where the trust explained its plans to sell the grade 1 listed Finsbury Health Centre and re-house the two general practitioners in a new building by demolishing an existing building it does not yet own in a conservation area where it may not get planning permission. The many architects present and English Heritage presented a powerful case for refurbishing the building, including how to install a lift, but the trust seems to want to sell to a developer to make money regardless of the views of the public it is supposed to serve.

Keep Our NHS Public (KONP) sees the underlying problem as the government's obsession with using the private finance initiative to encourage private companies into the health field, and increasing competition by using independent sector treatment centres and US corporations to provide GP services.

Doctors should find out what is happening in their areas by ensuring that someone attends their PCT and overview and scrutiny meetings. Tell us about these plans and join us either as individuals or by getting your BMA division to affiliate. The BMA's annual representatives meeting in 2006 supported our aims and principles, reaffirming its support in 2008 (motion 33).

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Competing interests: WDS is co-chair of Keep Our NHS Public (www.keepournhspublic.com).

1 Heath I. "Nothing is too good for ordinary people." *BMJ* 2009;338:b683. (17 February.)

Cite this as: *BMJ* 2009;338:b1201