Letters to the Editor

Awareness of living wills in the United Kingdom

SIR—We read with interest the results of questionnaire survey of British geriatricians regarding ‘Living wills and the Mental Capacity Act’ by Schiff et al. [1]. It is good to know that geriatricians favoured the use of living wills and that many had come across living wills while caring patients and felt it helped in end-of-life care planning.

We too feel that people in the United Kingdom have less experience of living wills than those in the United States. Schiff et al. interviewed 74 London inpatients (mean age 81) in 2000. More than three-quarters had not heard of living wills. In 2001, another study involving 56 London inpatients (mean age 77), 11 had heard of living wills but only one had executed such a will [2]. In contrast, a study in 1992 involving 214 American individuals (aged 65–91 years) found that 32 had written a living will and two-thirds of remaining respondents planned to do so [3]. The reason behind this may reflect difference in legal requirements. In the United States, under the Patient Self Determination Act, every individual has a statutory right to accept or refuse medical care and to execute a written advance directive [3]. In Britain, there is no such legal requirement.

Wide variations have been noted in studies regarding the agreement between surrogate and patient, and in some, it is no better than mere chance [1]. Doctors are not always skilled in anticipating the wishes of their patients. A patient’s health beliefs are important in determining the choice of treatment, and older people use very individualistic health beliefs in judging how to trade risks with preserving quality of life [4]. This is now particularly relevant in view of the shift of emphasis from physicians’ benign paternalism to patient autonomy. Living wills can promote patient autonomy.

We suggest that doctors should routinely take an ethics history, ideally, when patients are not seriously ill [5]. This focuses on living wills and the power of attorney as well as on views on artificial feeding, major surgery, ventilation, cardiopulmonary resuscitation, organ donation, communication with and decision-making by family members. Patients did not feel stressed when such issues were discussed with them in a previous study [2]. Spending a few minutes on these subjects when the patient is relatively well is preferable to trying to gauge their best interests during medical crises.

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The role of selective decontamination of the digestive tract in acute stroke

SIR—The study by Gosney et al. [1] that investigated the role of selective decontamination of the digestive tract (SDD) in acute stroke produced some interesting results. The data regarding the incidence of pneumonia are particularly intriguing. Using the results from Figure 2 in the paper [1], the results summarised in Table 1 can be obtained for all patients, those with a normal swallow and those with an abnormal swallow.

Using Fisher’s exact two-tailed test, the exact P-value for total patients is 0.0333 (0.0265 for the total patients mentioned in Table 1), whereas the exact P-value for those patients with a normal swallow is 0.462 and for those with an abnormal swallow is 0.127 (0.092 for the patients with abnormal swallow mentioned in Table 1). This would lead to the conclusion that there is no statistically significant difference between the SDD and placebo groups when considering the normal and abnormal swallow groups separately, but when combining them, there is then a statistically significant difference. How could this be? It would seem that the larger number in the normal swallow group who received SDD skew the total group result. Another possibility is that if it is inappropriate to combine the two groups, normal and abnormal swallow, together, because they may be two different disease processes and by doing so biases the total sample. When the numbers of patients who suffered pneumonia are small, this could give rise to a spurious correlation between the use of SDD and preventing pneumonia—also known as Berkson’s fallacy [2].

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Another interesting result that was missing from the paper was if the patients whose swallow improved were removed from the abnormal swallow group, would this alter the results and if so how? The writers’ conclusion that SDD gel might be useful in those with an abnormal swallow is warranted, but further larger studies are definitely needed.

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Reply

SIR—We thank both Dr Sutton and Dr O’Shea for the interesting further analysis of data from our paper. They have, however, further analysed patients according to their swallowing status, which we believe to be unscientific.

We have specifically not attempted to correlate swallowing status with clinical outcomes in this study for the following two reasons:

(i) The swallowing status was defined at presentation to ensure that an abnormal swallow was equally prevalent in the placebo and the active group and to determine the duration of gel administration. The intention was not to correlate swallowing status and outcome as this has already previously been described by this group [1].

(ii) As is known both clinically and in the research setting, a clinically safe swallow does not exclude aspiration as published in the same edition of Age and Ageing [2].

All patients in our study and for whom the initial swallow was abnormal had a daily nurse led assessment before a decision about oral intake. It is well known that swallowing ability may fluctuate from day to day and from time of the day, with worsening swallow associated with tiredness. Therefore, although we have this data, we do not believe that it is justified to move people from an abnormal to a normal swallow group.

We thus believe that combining groups with both normal and abnormal swallowing is more the situation seen in clinical practice and removes the potential inaccurate labelling of swallowing status, which is so well known.

We agree with the authors that further work is required in this area but hope that we may have opened this area of research up to others for the future benefits of patients both with and without abnormal swallow post-stroke.

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Using dietetic assistants to improve the outcome of hip fracture

SIR—Duncan et al. examined how improved attention to nutritional status and dietary intake, achieved through the employment of dietetic assistants, affected postoperative clinical outcomes among elderly women with hip fracture [1]. Participants were randomised either to receive the conventional pattern of nurse- and dietician-led care or to receive the additional personal attention of the dietetic assistants. The randomisation sequence was generated using blocked randomisation with a block size of 10 and was concealed using sequentially numbered, opaque and sealed envelopes. When blocked randomisation is used, it ensures that approximately equal numbers of participants are allocated to each of the treatments. If a constant block size is used and the randomisation sequence is not stratified, then the number of participants allocated to the two groups should only differ by a maximum of half the block size.

In this study, 318 women agreed to participate, and 153 of them were allocated to dietetic assistant care, and 165 were allocated to conventional care. This is an unexpected finding, given the block size. The maximum numerical imbalance that one would anticipate in a trial using a block size of 10 would be five, but here there is a difference of 12. Can the investigator explain why the unexpected discrepancy between

<table>
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<th>Selective decontamination of the digestive tract</th>
<th>Placebo</th>
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<td>No pneumonia</td>
<td>78</td>
<td>66</td>
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<tr>
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<tr>
<td>No pneumonia</td>
<td>78</td>
<td>66</td>
</tr>
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<td>Abnormal swallow</td>
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<td>27</td>
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Table 1. Pneumonia incidence in SDD versus placebo group