Correspondence

Optional quality – a terminal condition!

Rebecca Dunn's editorial 'Optional quality – a terminal condition!' is unfortunately based on *non sequiturs*. The fundamental difficulty is the equation of quality with adherence to guidelines. Where such guidelines are based on consistent clinical trial data, for instance in the management of myocardial infarction, this is likely to be true, but otherwise the opinions of professional associations may not be such a sound guide. Standardized assessments for the elderly are a good case in point: there is no validated evidence that the outcome is better when they are used than when they are not. The Abbreviated Mental Test Score and Geriatric Depression Scales at least roughly assess individual functions – memory and mood – which may be diagnostically, and in the latter case therapeutically, useful. The Barthel Index while simple, robust, and widely used, does not necessarily determine an individual's management as it does not relate to specific aspects of the patient's abilities to what is required in their home circumstances, so that putting a number on a patient's level of performance, while useful for groups and to some extent for tracking progress or otherwise, may not improve management. It may be that Wessex geriatricians do not use standardized assessments simply because they are not useful.

At the risk of sounding Luddite, one of the attractions of old age medicine is that, in its complexities, it is unlikely ever to be reducible to guidelines except with regard to the basic management of a few of its more common conditions. Outcome measures adjusted for admission case mix are a measure of quality much more worth striving for.

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Author's reply

Edmund Dunstan seems to ignore the reality of the National Health Service where purchasers are asking for evidence that the money they spend on geriatric services is of benefit to the population.

If as geriatricians we believe that what we do is of benefit we should be eager to demonstrate this using the tools available, where necessary highlighting their limitations.

Not to standardize practice and use the scales recommended by our professional bodies to measure function before and after geriatric intervention could lead purchasers to conclude we have something to hide.

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