Letters

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Frailty in old age

Jan De Lepeleire *et al*[1] have highlighted a very important area in the assessment of older patients. I fully endorse their emphasis on the ways that frailty may be reversed. However, frailty can be a prognostic indicator that should alert us to other issues, such as effective planning for end-of-life care. Frailty can be useful as a component in the identification of an irreversible decline.

Patients and relatives often need clear information about this state, that is also crucial for carers (professional or laypersons). At the end of life, frailty increases and may alert us to:

- the need to stop active or inappropriate interventions;
- to plan the place of end-of-life care;
- to ensure proper symptom control;
- to stop the revolving door cycle of fruitless admissions that can mar the final days/weeks of some older patients;
- to prepare relatives and carers that death is approaching; and
- to help relatives/carers prepare for death and appropriate grieving.

I was a little disappointed that the paper did not discuss this area in more detail. We are already moving away from the idea that palliative care/terminal care only applies to malignant conditions. Death is, at some point, inevitable. Part of our duty to patients and carers is to ensure that death is managed appropriately and with dignity. We need better understanding of when frailty is irreversible as well as an optimistic and rehabilitative approach to reversible factors.

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DOI: 10.3399/bjgp09X453846

Authors' response

We agree with Avril Danczak that palliative care for frail older people is an important issue, but our purpose was different. We wanted to reframe frailty and pre-frailty as tractable problems, even if temporary reversal of frailty is difficult in the current environment in many countries in primary care. The challenge is then to think about interventions to increase capability and function rather than provide prosthetic replacements for them.

Nevertheless, it is important to know when frailty becomes intractable. This is problematic, especially when cognitive impairment is severe and impedes communication. The predictions that practitioners make about the course of frailty are often wrong, with both underestimation and overestimation of mortality risk.

End-of-life care for frail older people has also tended to focus on what should be withheld, rather than on what should be done.[1] As Danczak says, the lack of clarity about prognosis and best practice in palliation can result in care that can easily fall below acceptable standards, and inappropriate emergency admissions to hospital.

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DOI: 10.3399/bjgp09X453855

Music in the waiting room

Music is common in the GPs' waiting room despite conflicting evidence of its effect on patients' anxiety,[1,2] and stress.[3] In primary care Zalewsky,[4] reports that 88% of patients find music improves their mood. Additionally, Kabler reports that in the UK 83% find it relaxing.[5] 'Muzak', can provoke strong feelings.[6] These studies report small numbers and have no comparator, and none of them report views of healthcare staff. We aimed to explore the perceptions held by patients

and staff of the effect music has on health and anxiety. A block controlled study was conducted in a London GPs' waiting room (2004) having gained ethics committee approval.

A pre-piloted questionnaire using an ill-health scale,[7] and anxiety levels, was administered to:

- staff and patients without music in the waiting room for 1 week (control group [CG]); and
- staff and patients with music for 1 week (intervention group [IG]).

Participants received an information sheet and questionnaire before their consultation. Children were excluded.

The sample size assumed the absence of music increases anxiety by 0.33 of a standard deviation, requiring 380 patients (90% power, 5% significance).

The response rate was 71% (370/523) participants and 97% (28/29) for staff with no significant differences in responders (% male, age, or response rate between weeks).

Music had no impact on health status (IG 65/100 versus CG 67/100, *P* = 0.21) or anxiety state (CG 72/100 versus IG 73/100, *P* = 0.79), where zero indicates very poor health or high levels of anxiety and 100 indicates good health or minimal anxiety. The majority of participants (61%) and half of staff (52%) were in favour of music; more so in the intervention group (IG 76% [116/153] versus CG 48% [92/190] *P*<0.001). Volume control was important for two-thirds. Four per cent of patients found it more difficult to talk to staff when music was playing compared to 7% (*P* = 0.44) with no music. Classical music was preferred (56% [110/166] participants, 67% [19/28] staff). Written comments from participants and staff were overwhelmingly negative:

'Sensory overload. Airport mentality'.

'I would not want to sit in the waiting room with music playing; I would rather wait in the street.'

There were also concerns for and by hearing impaired patients about hearing aids.

In summary, the playing of music had no significant effect on self-reported anxiety or health status. The majority of patients were, however, in favour of music in the waiting room and preferred classical music. Staff opinions were divided. A significant minority of staff and participants were strongly opposed.

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DOI: 10.3399/bjgp09X453864

Ethics of complementary medicine

Professor Ernst's discussion piece on the ethics of complementary and alternative medicine[1] leaves much to be desired as Brian Buckley suggests.[2] While statutory regulation is certainly no panacea, it does enable the professions to consider how they can provide their services in a proper and ethical manner. However, recent experience with the GMC appraisal and revalidation makes it clear that this process is far from perfect, but at least it is a step in the right direction. Professor Ernst fails to mention that the osteopaths and chiropractors have been statutory regulated for some years with their regulating body governing their education, professional behaviour, ethics, and continuing professional development. The acupuncturists and herbal medical practitioners in the UK have been debating their regulatory process with the Department of Health since 2000 and are also to be imminently regulated. Many of the other CAM professions have achieved some limited form of self-regulation and registration, with some expressing the intention of progressing to a more formal process which again will govern education, ethics, and continuing professional development. These attempts to improve the ethics, standards, and quality of complementary medical practice in the UK have now been ongoing for two decades and have been largely triggered by the professions themselves with recent help from the Department of Health. While this process is very far from being perfect, it presents a somewhat different perspective to that implied by Professor Ernst's paper.

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