Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 3 weeks of receipt of *Clinical Medicine*. Letters should be limited to 350 words, and sent by email to: clinicalmedicine@rcp.ac.uk

Updates in heart failure

DOI: 10.7861/clinmed.Let.23.6.1

Editor – The article by Rees *et al*[1] provided a useful overview of guideline-directed medical care for people with heart failure, but did not acknowledge the complexities of prescribing in older people with heart failure, especially those with comorbidities and significant frailty. There was no acknowledgement of the limitations of data derived from trials with tight exclusion criteria, representing a younger, fitter population than that familiar to many acute and primary care physicians and to geriatricians. The challenges of polypharmacy and concordance were not covered, and the exploration of patients' values or shared decision making did not merit a mention. A graph from the national heart failure audit is presented showing an excess mortality in those discharged from 'elderly care' wards with the unsubtle implication that this excess mortality might be related to reluctance to prescribe the 'four pillars' of heart failure treatment, without acknowledging the likelihood that those selected for care on such wards may be considerably more frail and have competing causes of death alongside heart failure. The heart is not the only organ, and it would be helpful to mention aspects such as advance care planning and the good work done by multidisciplinary teams where combined expertise has been shown to enhance quality of life and improve outcomes.[2] ■

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References

1 Rees OL, Wheen P, Anderson LJ. Updates in heart failure. *Clin Med* 2023;23:432–6.
2 Essa H, Walker L, Mohee K *et al*. Multispecialty multidisciplinary input into comorbidities along with treatment optimisation in heart failure reduces hospitalisation and clinic attendance. *Open Heart* 2022;9:e001979.

COVID-19 infection as a parameter in the CHA2DS2 vascular risk assessment tool

DOI: 10.7861/clinmed.Let.23.6.2

Editor – The study by Indurawa ***et al***[1] showing an increased prevalence of atrial fibrillation (AF) in hospitalised COVID-19 patients complements the findings of another study that also showed an increased risk of incident atrial fibrillation (AF) in hospitalised patients with COVID-19 infection. In that study 11,004 COVID-19-negative patients were matched with 3,090 COVID-19-positive patients, and 5,005 pre-pandemic patients were matched with 2,283 COVID-19-positive patients. After adjusting for demographic factors and comorbidities, COVID-19 positive patients had a 1.19 times odds (95% confidence interval (CI) 1.0–1.41) of developing AF compared to COVID-19 negative patients, and 1.56 times the odds (95% CI 1.23–1.41) of developing AF compared to pre-pandemic patients.[2]

Even in the post-hospital phase of COVID-19 infection, patients who have experienced a COVID-19 episode are at increased risk of incident arrhythmia (including AF).[3] In this study, risk of arrhythmia was assessed at 6 months in mutually exclusive cohorts comprising non-hospitalised patients with COVID-19, people who were hospitalised for COVID-19, and people who were admitted to intensive care for COVID-19 during the acute phase (30 days) of the infection. All three categories were patients who had already been discharged from hospital at the time of evaluation. Beyond the first 30 days of illness, patients with COVID-19 who had been hospitalised for this infection had an increased risk of arrhythmia (hazard ratio 8.4, 95% CI 7.18–9.53).[3] What is doubly disconcerting is that COVID-19 is also associated with a hypercoagulable state, as shown in the literature review by Abou-Ismail *et al*,[4] thereby compounding the risk of cardiogenic thromboembolism. In that review the increased risk of thrombosis appeared to prevail despite anticoagulation. The proposed pathophysiology of COVID-19 coagulopathy is that it is initiated by the proinflammatory environment of COVID-19 infection. In that proinflammatory milieu participants in the aetiopathogenesis of hypercoagulability include cytokine release, localised intravascular coagulopathy, participation by monocytes and macrophages, neutrophil extracellular traps, complement-mediated microangiopathy and dysregulation of the renin-angiotensin system.[4]

For all these reasons history of COVID-19 infection deserves inclusion as one of the parameters in the CHAD2 vascular risk assessment tool. ■

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References

1 Indurawa I, Cattermole E, Paisey C *et al*. Higher incidence of new atrial fibrillation in hospita;lised COVID-19 patients compared to lower respiratory tract infection, however, less patients prescribed anticoagulants at discharge. *Clin Med* 2023;23:478–84.
2 Wollborn J, Karamvov S, Fields KG *et al*. COVID-19 increases risk for the onset of atrial fibrillation in hospitaiized patients. *Sci Rep* 2022;12:12014.

3 Al-Aly Z, Xie Y, Bowe B. High-dimensional characterization of post-acute sequelae of COVID-19. *Nature* 2021;594:259–64.
4 Abou-Ismail MY, Diamond A, Kapoor S *et al*. The hypercoagulable state in COVID-19: incidence, pathophysiology, and management. *Thrombosis Res* 2020;194:101–15

Addressing obesity and homelessness via ChatGPT

DOI: 10.7861/clinmed.Let.23.6.3

Editor – I read with great interest the July 2023 edition of ClinMed, which focused on the complex issues of obesity and also featured homelessness.[1] The chosen title of the editorial – 'Tough on crime, tough on the causes of crime' – resonates profoundly as it highlights the interconnectedness of health challenges within our society. This edition has effectively showcased the evolution of medical thinking, underscoring the multidimensional nature of these problems.

The outdated belief that obesity is merely a result of excessive calorie intake is debunked through the compelling articles presented. The understanding of obesity's multifactorial aetiology has paved the way for a more holistic approach, appreciating the diverse factors that contribute to its development and complications. The depth with which the edition covers a wide spectrum of subjects, from aetiology and prevention to management and care, demonstrates the multidisciplinary nature of addressing obesity.

Similarly, the articles on homelessness shed light on a dire issue that reflects systemic failures and societal inequalities. The harrowing health outcomes endured by those experiencing long-term homelessness emphasise the urgency of tailored care that addresses individual needs. These articles, collectively, remind us of the ethical responsibility we hold as physicians to prioritize equitable care over institutional targets.

In this context, the role of physicians extends beyond clinical practice. We are tasked with translating our understanding of complex health issues into actionable strategies for both patients and communities. The increasing body of medical knowledge, combined with emerging technologies like ChatGPT, can enable us to bridge this gap more effectively. ChatGPT, with its ability to synthesise and disseminate information,[2] can facilitate communication not only within the medical community but also with the public. It can serve as a tool for physicians to engage in meaningful discussions about health challenges, dispel misinformation, and advocate for informed policies.

As we move forward, the challenges of providing equitable care and tackling the societal determinants of health remain formidable. However, this themed edition is a testament to the potential for collaboration among healthcare professionals, researchers and the wider community. It prompts us to consider how we, as physicians, can contribute not just to individual health but to the strength and wellbeing of the community at large. ■

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References

1 Emmanuel A. Tough on crime, tough on the causes of crime. *Clin Med* 2023;23:281.
2 Sohail SS, Farhat F, Himeur Y *et al*. Decoding ChatGPT: a taxonomy of existing research, current challenges, and possible future directions. *J King Saud Univ Computer Information Sci* 2023;35:101675.

The Situational Judgement Test: not the right answer for UK Foundation Programme Allocation

DOI: 10.7861/clinmed.Let.23.6.4

Editor – Allocation to UK Foundation Programme training posts has long been an issue of contention. Following recent analysis of the allocation process, the UK Foundation Programme Office has now moved away from the use of a Situational Judgement Test (SJT) and the Educational Performance Measure (EPM). Although SJTs have been proposed as a suitable tool for aiding selection decisions, our article last year demonstrated that this was not the case when considering allocation of places in the UK Foundation Programme.[1]

We were interested therefore to hear of Sahota and colleagues' strong defence of the SJT[2] and have carefully considered the points they raise. However, we remain unpersuaded by the arguments made – indeed we have discussed the issues with a wider group of senior academics from UK medical schools (several of whom are additional signatories to this letter), and it is our continued belief that the SJT was not an appropriate method of determining Foundation Programme allocation. To further illustrate this, we provide additional examples of the potential consequences of how an individual candidate's allocation could be dramatically impacted by factors outside of their control.

We estimate that the standard error of measurement (SEM) of the SJT is approximately 16 SJT points, or around 2.5 points of a student's total ranking score out of 100 (0.38 standard deviations). For a student with a ranking score at the mean, changing their SJT score by 1 SEM would change their position in the ranking by around 1,200 places (out of 8,000 or so applicants). This could inevitably impact their destination for the Foundation Programme – by chance alone. This effect is before we consider any unreliability due to issues related to a lack of concordance among the experts who determine the 'correct' response keys. The SJT Technical Report for 2021/22 notes that a Kendall's W of 0.5 was considered satisfactory.[3] This is equivalent to just 50% agreement and below the 0.6 required for good agreement. Of course, some items will have higher agreement rates, but clearly there is doubt over the best course of action for some scenarios and importantly, this is recognised by the candidates, which in turn can lead to low confidence in the fairness of the assessment.

Sahota *et al* dispute that the SJT disadvantages Black and Minority Ethnic (BAME) students. However, SJT technical reports[3] consistently state a difference in mean scores between BAME and white students of around 20 points, which equates to approximately 3 points in a student's total ranking score. Here we find an even bigger impact on the average student's ranking than with 1 SEM of SJT scores – approximately 1,500 places. Why BAME students do not perform as well as their white peers on the SJT is unclear, but this level of impact is not acceptable given its effect on allocation.

Sahota *et al* also question the statistical power and the interpretation of multivariate statistics in relation to the