Reviewer’s report

Title: The MRC Trial of Assessment and Management of Older People in the community: objectives, design and interventions

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The MRC trial of assessment and management of older people in the community: objectives, design and interventions.

The United Kingdom’s Medical Research Council encourages all researchers designing and carrying out complex intervention studies to invest time in both their detailed development and description. This allows clearer interpretation of results, easier replication of studies and faster incorporation of results into systematic reviews and meta-analyses.

Professor Fletcher’s team has complied with this encouragement admirably, describing (albeit briefly) the policy context which gave rise to their trial, the complexity of its design (including a thorough account of the reasoning behind the sample sizes), the nature of the assessment stages and (less satisfactorily) the types of clinical case management. This will allow us to interpret subsequent findings, which are likely to be plentiful, but replicators and meta-analysts may not have much to do, because this trial is large enough to give definitive answers to some of the research questions posed a decade ago. I have the following comments on the paper:

1. The policy context which begat the study is outlined (somewhat sketchily) and suggests that the lack of convincing evidence of benefit from systematic assessment of older populations did not inhibit the introduction of such a programme in 1990. The authors might make more of the evidence that had accumulated prior to 1990, suggesting that comprehensive population screening would not be an appropriate policy. [DISCRETIONARY REVISION] The United Kingdom became the first country to introduce a nationwide screening programme for older citizens without plausible evidence of health gain, and has been followed by others in Europe mesmerised by the rising demographic tide. The MRC trial, therefore, was launched in a situation where evidence and policy were divorced, and risked becoming the intellectual underpinning for shaky policy foundations in which there was little evidence of balanced equipoise in scientific thinking. Critics of the emphasis placed on the RCT as an evaluation technique might have used this study as an example of an experimental method applied to the wrong question. It is to the credit of trial team and its steering group that they escaped from this awkwardness
by developing a complex design that tested an idea not yet enshrined in policy, comprehensive geriatric assessment. In addition they have evaluated different forms of brief assessment, which they rightly point out will inform the National Service Framework for Older People, another policy initiative launched before its evidence base had cooled, let alone taken shape.

2. The brief assessment instrument identifies people who are seemingly isolated, very disabled, very poor, very deaf or visually impaired, depressed or demented, incontinent, taking 7 or more medications on a regular basis, or having acute signs of major pathologies (e.g. short of breath when sitting, vomiting or coughing up blood). This is a high morbidity group, with I suspect high probabilities of already being engaged with medical and possibly social care. In the arm of the trial where the brief assessment triggers a fuller assessment only patients with one or more of these characteristics could proceed towards case management, either by a primary care team or a multi-disciplinary geriatric team. It will be interesting to see how many new cases previously unknown to services are identified, and how known cases whose care is already partitioned across agencies and services are dealt with. Intriguing situations could develop where individuals with complex and multiple pathologies find themselves randomised to different patterns of care from those that they had previously experienced, and it will be useful to learn about these scenarios in subsequent publications about the methodological problems of the study. [COMPULSORY REVISION]

3. The second stage assessment is focussed more on disease than disability, suggesting that the research team did not hold the view that the major problem in the ageing population is unrecognised functional loss, rather than undiagnosed pathology. This is an appropriate stance to take if the underlying hypothesis is that the rule of halves applies across a broad domain of common diseases. A focus on occult carcinoma, unexplained weight loss or undetected bradycardia is also legitimate, of course, when the objective is to reduce mortality, whereas a focus on improving mobility, vision and hearing might improve quality of life, reduce depression and increase fitness by addressing the complexities of disablement as a process. Referrals to audiology, opthalmology and the continence advisor all occur in the research protocol, but the trial compares the effects of two different types of medical management of clinical diseases, not two attempts to interrupt or modify the disablement process. Interestingly, the management "models" being compared seem to be normal general practice care and normal geriatric medicine care, so we may not be surprised if the trial shows that comprehensive geriatric assessment is best carried out by specialist multi-disciplinary teams, this being the assumption underlying current practice. The opposite result - that general practitioner care reduces mortality more than specialist care for patients of similar morbidity - would be an interesting surprise. These issues need addressing in the paper. [COMPULSORY REVISION]

4. Further descriptions of these management processes actually were might be helpful to understand the trial results, because of the variations in clinical practice and service organisation in different places. "Multi-disciplinary working" is as meaningless as "primary health care team" as a description of clinical care processes. Similarly, the criteria for referral to primary care team (PCT, not to be confused with primary care trusts) or geriatric evaluation and management (GEM) teams need further elaboration. It is not clear what research question is being asked when an old man with nocturia more than twice nightly is randomised to direct referral to a GEM team. Likewise, is the randomisation of a patient with a recent history of vomiting up blood to general practice care actually testing two types of care, since rapid referral for specialist assessment seems highly likely? The hypothesis here may be that comprehensive geriatric assessment is no better than normal GP care (including referral to appropriate specialists) in the management of haematemesis in older people, but who suggested it was? These issues need addressing in the paper. [COMPULSORY REVISION]

5. What might be learned from this trial? We will know a great deal about the pattern of morbidity in the
older population, which should inform service commissioning. The trial's brief assessment process seems likely to yield useful guidance for the single assessment process of the NSFOP, but how much impact the trial findings will actually have depends on whether the single assessment process functions as a case finding and case management tool or as a eligibility test for accessing care. The outcome of the management interventions might be more of a puzzle. The authors are not testing management models, but two types of normal care that have traditionally co-existed in a hierarchical relationship. It seems unlikely that the findings will have significance beyond the NHS, and we may be debating their meaning within it, especially of the benefits are significant but small. Then the enthusiasm of trialists and the particular characteristics of the PCTs and GEMs recruited to the study might just be the deciding factor in achieving benefit, which may elude jobbing geriatricians and GPs pressed to apply the lessons of research. The authors could useful expnd their discussion of both the policy context into which their findings will be launched, and the limitations of evidence derived from RCTs.

[COMPULSORY REVISION]

Advice on publication: Authors should respond to suggested revisions.

**Competing interests:**

None declared.