## Role of B-natriuretic peptide in perioperative assessment

*Sir,*

Dr Collinson (vol 70(6), 2009, p. M84) highlighted the role of B-type natriuretic peptide (BtNP) in cardiac failure. In addition to the mentioned uses of BtNP in primary care and in diagnosis of acute heart failure, the authors believe that BtNP has an important role in anaesthesia, particularly in the perioperative assessment of cardiac risk.

There is a direct association between increasing levels of BtNP preoperatively and risk of postoperative cardiac death, non-fatal myocardial infarction and acute pulmonary oedema (Dernellis and Panaretou, 2006). A BtNP level of 40 pg/ml or more is associated with a fivefold increased risk of developing new electrocardiographic abnormalities or raised postoperative cardiac troponin levels (Cuthbertson et al, 2007). In terms of postoperative risk, patients with high levels of BtNP have longer intensive care unit stays, an increasing incidence of renal impairment and require more inotropic support than patients with low levels of BtNP (Rodseth, 2009).

The challenge in using BtNP for perioperative risk assessment in anaesthesia is the lack of an optimal discrimination numerical value of BtNP in predicting cardiac outcomes in the perioperative period. More large scale randomized controlled trials are required to address this, which will have an increasingly important role in future perioperative assessment.

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## Prescription errors and psychiatric service delivery

*Sir,*

Prescription errors are not well researched in psychiatry despite having the potential to cause patient morbidity and mortality. Initiatives by the American Psychiatric Association and National Patient Safety Agency have highlighted the need for more knowledge in this area (Rothschild, 2007).

The authors screened drug charts of 200 consecutive inpatients at two psychiatric units in 2007 for prescription errors. No significant differences were detected between the two samples except that the rate of non-recording of allergy status was 41% ($n$=100) in the suburban unit and 15% ($n$=100) in the inner-city unit. Junior doctors responsible for writing prescriptions had similar recruitment and supervision arrangements and the prescribing policies of two psychiatric units were also identical. The suburban unit, however, had adopted a functional model (separate psychiatric teams for inpatient and community and no ward rounds) while the inner-city unit provided continuity of care through the same psychiatric team looking after the patient in the community and at the inpatient unit.

Despite the small sample, this highlights an important issue about models of psychiatric service delivery. Does traditional psychiatric practice ensure better patient care through existing patient knowledge, communication, and supervision of junior doctors via ward rounds? If Lord Darzi (2008) intends to put the patient at the centre of the psychiatric health-care system, he needs to seek answers to such questions on one hand and ensure quality training and supervision of junior doctors on the other.

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## Should a person who wants to die always be considered a patient?

*Sir,*

In many countries, patients who attempt suicide are usually hospitalized if there is felt to be a risk to the patient's safety. Suicide attempts are a symptom of a wish to die or a plea for help from suffering people. This suffering of the mind can have a medical cause, but could there be untreatable causes of suicide attempts, or at least a non-medical condition of 'desire to die'?

While working in prehospital emergency care we saved a patient, against his will, from probable death, following a call from a passer-by. Examination in hospital found no symptoms of psychosis, depression, chronic intoxication or any other chronic medical condition. He explained that he had severe social problems that he could not handle without killing himself.

Given his desire to die and the chance that curable depressive symptoms might have been missed, he was hospitalized. However, does the doctor have the right to overpower his determination if he doesn't have any medical condition except his wish to die? If we had respected his choice and left him alone he might have committed suicide.

Doctors are trained to save lives (with the exception of palliative care). In some countries (such as France), the law obliges all citizens, including physicians, to save others' lives if possible, even if it goes against their right to chose. If someone loses his capacity of choosing to die, this person has lost his power to live. The medical context should not be an excuse to override personal liberty, even though examination is essential to diagnose a treatable medical cause.

A debate is needed about what doctors should do when faced with a patient who wants to die, especially where clinical examination is difficult. This is particularly important in countries where the law forces every subject to save lives if they can, in balance with the liberty to die and to live.

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