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In Reply Gillespie and colleagues correctly note that health care providers who mostly practice in the nursing home may not necessarily have completed specialty training in geriatrics or care of persons in the nursing home setting. Our use of the term “SNF-ist”¹ (ie, physicians, nurse practitioners, and physician assistants concentrating their practice in the nursing home or skilled nursing facility [SNF] setting) classified health care professionals exclusively based on their volume and site of practice. In our Research Letter,¹ we do not make any assertions about SNF-ist level of training, board certification, or their quality of care.

Our study¹ identified marked growth of SNF-ists who concentrate their practice in the nursing home setting. The concentration of physician clinical activities in a single site of care may enhance their efficiency. Alternatively, the growth of physicians who exclusively focus their care in the nursing home may further fragment care for frail, older persons experiencing transitions between home, hospital, and postacute care settings. Understanding the advantages and disadvantages of increased concentration of clinicians in the nursing home setting is an urgent research priority. The emergence of hospitalists has seen a substantial reduction in the number of primary care physicians serving as attending physicians in the hospital setting. Therefore, it is not unexpected that a similar phenomenon is occurring in the context of nursing home care.² As we shift from a fee-for-service system that incentivizes productivity in one setting of care to value-based payments, an important unanswered question is: what is the best model of care for frail, older persons with multimorbidity?

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Conflict of Interest Disclosures: None reported.

Additional Contributions: We thank Jennifer Bunker, BA, MPH; Vincent Mor, PhD; and Susan Mitchell, MD, MPH, who all reviewed and commented on this manuscript.

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Limitations of Observational Data in Interpreting SPRINT Results

To the Editor We read with interest the Research Letter in a recent issue of *JAMA Internal Medicine* by Sexton et al¹ on the rates of syncope and injurious falls in Irish Longitudinal Study of Aging (TILDA) participants 75 years or older meeting eligibility criteria for the Systolic Blood Pressure Intervention Trial (SPRINT). Their work highlights the principle that clinical trials are a starting point for therapeutic discussions but that medical care must be individualized to the patient's estimated risk. However, there are several important differences between these 2 studies that merit discussion when considering the higher rates of syncope and injurious falls observed in TILDA.

First, it is puzzling that SPRINT-eligible TILDA participants seem in many ways healthier than their SPRINT counterparts (ie, faster gait speed and less frailty). Second, the definition of an injurious fall in TILDA was a self-report of a fall serious enough to warrant medical treatment. In SPRINT, 5.5% of participants randomized to standard-treatment experienced injurious falls that led to an inpatient hospitalization. This frequency increases to 14.1% (27.3% in TILDA) when injurious falls that required assessment in an emergency department but did not lead to hospitalization are also included.² Third, nearly 10% of individuals screened for SPRINT were deemed ineligible owing to a systolic BP less than 110 mm Hg following 1 minute of standing. It is unclear if such individuals were excluded in TILDA, which could contribute to a higher incidence of syncope and falls.

Fourth, SPRINT-eligible TILDA participants were 100% white and majority female (58.7%), while 23.5% of SPRINT participants were black or of Hispanic race/ethnicity and were majority male (62.0%). Because women and white patients tend to have higher rates of falls (an observation that also holds in SPRINT),^{3,4} this demographic difference could also contribute to a higher rate of injurious falls in TILDA. Finally, it is concerning that 26.3% of TILDA participants did not complete the wave 3 assessment. The combined rate of loss to follow-up, withdrawn consent, or death was only 11.6% in SPRINT through a median follow-up of 3.14 years.²

We do not believe that the rate of self-reported injurious falls in TILDA implies that implementation of intensive BP control would result in harm. Indeed, SPRINT demonstrated no increased risk of injurious falls in participants 75 years or older who were randomized to a systolic BP target of less than 120 mm Hg compared with those randomized to a target of less than 140 mm Hg.²

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Conflict of Interest Disclosures: None reported.

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In Reply We agree that our study does not prove that applying the SPRINT protocol to those patients 75 years and older will lead to harm. However, we believe our study¹ questions the external validity of the injurious falls and syncope rate seen in SPRINT, because the baseline rate in the target population appears to be considerably higher than the standard care arm of the trial.² This fact emphasizes the need for physicians to individualize the application of intensive hypertension treatment for elders.

TILDA is a prospective cohort study based on stratified random sampling of the Irish population ($n = 8175$ participants at wave 1) and is representative of community-dwelling adults 50 years or older without severe cognitive impairment. All participants were invited to have a health assessment, either at a dedicated research center or in the participant's home (to counteract bias from overrepresentation of healthier participants). In the overall cohort, 74% of participants completed the first 3 waves, and 6% died. For patients ages 70 to 80 years, retention in TILDA is higher than other aging studies.³

Attrition between waves 1 and 2 in our study¹ assessing SPRINT generalizability ($n = 407$) is detailed in Figure 1 included in our Research Letter.¹ Between waves 2 and 3, 36 participants died, 4 were lost to follow-up, 19 refused to participate, and 1 withdrew. Therefore, the total attrition, including deaths between waves 1 and 3 in those who met inclusion criteria for SPRINT participants 75 years or older, was 26% ($n = 107$ of 407), with death accounting for 14% ($n = 57$ of 407). Given this mortality prevalence, we believe our estimates for injurious falls and syncope are likely conservative, excluding the most vulnerable participants.

This death rate also refutes any suggestion that TILDA participants may be healthier than their SPRINT counterparts. Normative values for gait speed for community-dwelling individuals in Ireland⁴ suggest a gait speed of 0.8 m/s corresponds to the fifth centile for a typical 80-year-old man.⁴ Gait speed and frailty were measured by different methods in TILDA and SPRINT to an extent that direct comparison is not meaningful (outlined in Table 1 in our Research Letter¹). TILDA reported frailty by Fried criteria while SPRINT reported a unique index.^{5,6} While measures of frailty vary widely, the Fried index is perhaps best validated for harmonization.

TILDA participants were asked if the injurious fall required medical attention but not specifically whether these lead to an emergency department visit or hospitalization. Nonetheless, within the Irish health care system, the overwhelming majority of these events are evaluated in the emergency department. In TILDA, participants have their systolic blood pressure recorded within the first minute after standing rather than exactly at 1 minute. Using this data, the proportion of those included in this substudy who had a standing systolic blood pressure less than 110 mm Hg was approximately 1% rather than 10% in SPRINT.¹

While we acknowledge that racial heterogeneity may contribute to fewer falls, the preponderance of women in TILDA reflects the general population both in Ireland and the United States. Other possible reasons for fewer injurious falls in SPRINT might include: improved general care in randomized trials, early stoppage of the trial, unclear power to detect a difference in injurious falls and an element of volunteer bias inherent to all randomized trials.

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Conflict of Interest Disclosures: None reported.

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Medical Assistance in Dying—Unanswered Questions

To the Editor Medical Assistance in Dying (MAID) became Canadian law after Royal Assent on June 17, 2016. In their Perspective published in a recent issue of *JAMA Internal Medicine*, Quinn and Detsky¹ described MAID in a patient with cancer who was “fading away...[and] wanted to be in control of his death.”^{1(p1251)} Both authors and a palliative care physician participated in MAID, and the authors concluded that “in this circumstance it was the right care, for the right patient, at the right time.”^{1(p1252)} They justified MAID by appealing to arguably an unrestricted legal interpretation of individual