would be able to attend. In order to make this a reality, it requires innovative revision of consultant job plans so that they are both re-numerated adequately for their time and released from other duties during acute on call.

There is no mention of the benefits of structured consultant-led handover as a valuable learning experience during which results can be reviewed and diagnoses questioned. In addition the significant improvements in information technology that have occurred over the last few years mean that patient's results are available anytime day or night.

Junior doctors also have a responsibility themselves to ensure that they follow-up cases that they have admitted and use any changes in diagnosis as ideal topics for case-based discussions.

In conclusion we must ensure that the benefits to patients of new ways in working also extend to delivering quality training for our juniors and this may require a paradigm shift in consultant working practices.

D KENDALL
Project director

R HAZARIKA
Assistant director

J HARROP
Medical advisor

NHS North West Junior Doctor Advisory Team

Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

Do medical patients know the name of their consultant?

Introduction

When taking a history from people who had been inpatients at other hospitals we were struck by how infrequently they knew the name of the consultant who had been responsible for their care. This is a poorly documented topic, and we decided to see if inpatients in our own hospital knew the name of their consultant. Queen Mary's is a district general hospital in Kent which does not have an acute admitting unit/ward. In an average 24-hour period there are 18 medical admissions. New patients are admitted directly to any one of eight medical wards depending on the specialty and on bed availability. Care of new patients is transferred to the ward-based medical team the following working day. At the time of our survey there were 10 general and elderly medicine physicians with inpatient beds, and it was hospital policy not to have the patient nor consultant name above the bed.

The study was undertaken to determine how frequently patients knew the name of the consultant responsible for their care, and if this was influenced by length of stay or by whether the patient had met their consultant.

Methods

Initial data were collected in September 2006. A proforma was devised to standardise questions. Lists of medical admissions were obtained daily over eight days from the on-call medical team and the Care Records Service (information technology system). Data of patients who were still in hospital on the afternoon of day three of their admission, provided that at least two of the days had been normal working days, were collected. This was to ensure patients had had an opportunity to be seen on ward rounds by their new team.

A month later, four medical wards were surveyed and data collected from patients who had been on the ward for at least one week.

Patients were excluded if they were over 75 years and had an abbreviated mental test score (AMTS) of less than seven out of 10, or were under 75 years with a history of confusion or memory problems.

Results

Of 142 patients admitted over eight days in September 2006, 82 were still in hospital on day three of their admission. Of these 27 (33%) were excluded. Of the 55 included, 20 (36%) knew the name of their consultant.

When the survey of four medical wards was conducted one month later, of 108 possible patients, 67 (62%) were excluded as they had been an inpatient for less than one week, or had an AMTS of less than seven out of 10. Of the 41 included, 19 (46%) knew the name of their consultant.

Of the total 96 patients questioned, 77 (80%) had had a documented ward round with their new consultant. Of those that had met the physician on a ward round, 46% knew the name of their consultant, compared with 21% who had not met them ($p=0.0125$). Length of stay did not significantly affect whether patients knew the name of their consultant.

Discussion

The results of this 'snapshot' show that only a minority of hospital inpatients know the name of the consultant with overall responsibility for their care. Not surprisingly, patients were significantly more likely to know who their consultant was, if they had met them on a ward round. On ward rounds most physicians introduce themselves, but we all tend to forget names. It would seem sensible to have the consultant's name above the bed, but some trusts

deem this paternalistic or a breach of confidentiality. We suggest that when doctors in training introduce themselves they should tell patients which consultant team is looking after them.

MARCUS ANTHONY PITTMAN
Specialist trainee

GEETA AGGARWAL
Specialist trainee

CHARLES DAMIEN SHEE
Consultant chest physician

Department of Respiratory Medicine, Queen Mary's Hospital, Sidcup

Long-term oxygen therapy (LTOT) – is it always appropriately prescribed?

When used appropriately long-term oxygen therapy (LTOT) improves mortality in patients with chronic obstructive pulmonary disease (COPD).[1,2] However, LTOT should only be prescribed when specific criteria have been met.[3] British Thoracic Society (BTS) guidelines suggest that all patients requiring LTOT should be assessed within secondary care by a respiratory physician-led service.[3] Following introduction of the national integrated oxygen service in 2005, a wide range of healthcare providers, both in primary and secondary care, have been allowed to prescribe LTOT by completing a home oxygen order form (HOOF). Since then our local primary care trust (PCT) has become aware of rapidly escalating oxygen costs. We therefore examined all local LTOT prescriptions to determine whether this rise in use was appropriate.

The study was performed in Bath and North East Somerset (BANES) PCT (population 168,000) which is served by a single secondary care institution, the Royal United Hospital (RUH) Bath. All active HOOFs for LTOT were reviewed and cross-referenced against both the hospital oxygen assessment service database and hospital notes. Where patients had not been assessed at the RUH, primary care physicians were contacted for further information.

In total, 174 patients were receiving LTOT on 1 September 2007. Of those, 144 (83%) sets of hospital notes were available for review; 63% of HOOFs were completed in primary care and 37% in secondary care.

HOOFs were generally poorly completed, with 51% of forms missing more than three essential items of data. Only 42% of HOOFs documented a diagnosis and thus missing diagnoses were extrapolated from hospital notes. Final diagnoses included COPD (54.2%), other respiratory conditions (13.3%), cardiac disease (10.4%), palliation (17.4%) and no diagnosis available (4.7%).

Further analyses were performed on the COPD cohort (79/144). A third (26/79) of prescriptions had inappropriate rates or duration; some had durations as low as 30 minutes or vague descriptions such as 'in the room', 'medium' or 'normal'. Only 46/79 (58%) of COPD patients had been formally assessed prior to initiation of LTOT. In total 37/79 (46%) of COPD patients had been inappropriately prescribed LTOT (25 never referred for assessment, three referred but failed to attend and nine had been assessed as not requiring LTOT).

Inappropriate LTOT prescriptions were primarily completed by primary care physicians (29/37 cases). Of those completed in secondary care, 75% (6/8) inappropriate prescriptions were completed by non-respiratory physicians.

It is often not appreciated that oxygen is a drug and should therefore be prescribed with due care. Inappropriate LTOT prescriptions can significantly limit patients' independence and in some cases can cause significant morbidity. This study demonstrates that oxygen prescribing is generally poorly performed by both primary and secondary care. HOOF prescription forms were generally poorly completed, with many essential data fields left unfilled. Despite the presence of an easily accessible local assessment service a significant number of patients on LTOT had not undergone formal assessment. Even in those with COPD, where clear national guidelines exist, LTOT was prescribed inappropriately in 46%. These findings have significant health and economic implications and suggest more education is needed in LTOT assessment and management.

RH MASON
Clinical research fellow and specialist respiratory registrar
The Churchill Hospital, Oxford

J SUNTHARALINGAM
Consultant respiratory physician
The Royal United Hospital, Bath

References

1 Report of the Medical Research Council Working Party. *Lancet* 1981;1:681.
2 Is 12-hour oxygen as effective as 24-hour oxygen in advanced chronic obstructive pulmonary disease with hypoxemia? (The nocturnal oxygen therapy trial – NOTT). *Chest* 1980;78:419–20.
3 British Thoracic Society (BTS) Working Group on Home Oxygen Services, Sub-Committee of the Standards of Care Committee of the BTS. *Clinical component for the Home Oxygen service in England and Wales*. London: BTS, 2006.