

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.

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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.

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References

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- 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.
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