

# letters to the editor

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## Acute medical care

Editor – We read with interest the article by Ward *et al* (*Clin Med* December 2009 pp 553–6). In this article the authors identified a number of areas in which acute medical practice varies across different sites in a national survey. We have recently conducted a comprehensive regional survey in Wessex and have found similar variations. In our survey, responses were received from all nine of the acute hospitals in the region.

Eight of the nine acute units have at least one acute medicine consultant in post. The ability to recruit to these posts locally has been achieved, in part, due to the early development of a training programme in 2003. However, there remains a lack of uniformity in the structure of the services within this region. Even the titles of the units varied widely, with six different names being used; only one of the units had adopted the Royal College of Physicians (RCP) preferred title of 'acute medical unit' (AMU).

Although five of the nine units were purpose built, none had been able to achieve the 'emergency floor' model proposed in the RCP report, where co-location with critical care, emergency department and radiology was deemed desirable.<sup>1</sup> Near-patient testing was available in eight of the nine units, compared to <50% in the national survey. Six provided an ambulatory care service, eight provided direct general practitioner access and all used an early warning score for prediction of illness severity. Links with pharmacy were particularly strong in our survey, with all AMUs providing a dedicated pharmacy service. However, only one of the units was able to provide a dedicated AMU physiotherapist, and a weekend therapist was provided in only four units.

Ward *et al* emphasise the progress that acute medicine has made over the last 10

years, but a uniform service across the UK remains some distance away. Indeed, it is likely that their results underestimate the national variations given that 31% of the hospitals failed to respond. Hospitals without a coherent, structured acute medicine service may have been less likely to respond to an acute medicine survey. Collating data on a regional basis may be one way to achieve a higher response rate, as achieved in our survey.

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## A new era for stroke patients

Editor – The commentary by Smyth on the recent Royal College of Physicians stroke conference advocates computed tomography (CT) as first line imaging for acute stroke, rather than magnetic resonance imaging (MRI) (*Clin Med* December 2009 pp 557–9). We agree CT imaging is adequate for assessing patients for thrombolysis, but MRI of stroke is superior to CT.<sup>1</sup> With the use of limited sequences, rapid imaging is possible with greater accuracy than CT in the district general hospital setting and can be performed in the majority of acute stroke patients.<sup>2,3</sup> MRI also allows

a more accurate determination of the vascular distribution of the event and the pattern of infarction can also provide clues to the cause of the event.<sup>4,5</sup> Multimodal MRI does not appear to carry the risk of multimodal CT scanning.<sup>6</sup> In our view, MRI is the optimal first line investigation for stroke and should be more widely used.

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## Are we dressed to impress?

Editor – The study from Gherardi and colleagues is both welcomed and timely (*Clin Med* December 2009 pp 519–24). The physical appearance of doctors in hospitals has changed substantially over the past five years – the loss of the white

coat, banning of neckties, widespread introduction of surgical scrubs (also for non-medical staff) and the 'bare below the elbow policy'. These changes have all been made to reduce the incidence of hospital-acquired infections (HAIs), though no trial has shown these measures to have had this effect.

It is of interest that the authors used pictures of male doctors wearing neckties. One wonders if their results would have been any different had they not included a necktie? In 2006, the board of science of the British Medical Association (BMA) published a guide for healthcare professionals in which neckties were described as of 'no beneficial function'.<sup>1</sup> This same description was used in the Department of Health's (DH) guidance document published the following year.<sup>2</sup>

Actually, neckties do give a more professional appearance to a male doctor and thus stating they have no beneficial function seems wholly inaccurate. Neckties have previously been shown to carry microbes, but again no evidence exists that ties can actually transmit infections between patients.<sup>3</sup> Similarly, there are no trials proving that removing neckties in a hospital leads to a reduced rate of HAIs.

The findings from this study echo the results of previous surveys which have found that patients do draw confidence from a professional appearance of their doctor. The healthcare profession understands that serious measures are necessary to reduce the rate of HAIs and to that end the widespread drive for improved hand hygiene has been highly successful. However, this study adds further weight to the argument that the doctor-patient relationship is affected by our physical appearance at work, and thus a balance needs to be struck between maintaining the confidence of our patients while striving to minimise the risk of HAIs.

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## Failure in prescribed medications being given to inpatients

Editor – Green and colleagues (*Clin Med* December 2009 pp 515–8) are right to highlight the problem of prescribed medications not being administered but appear to have omitted one of the more common reasons for this occurrence – failure of communication between medical and nursing staff. In our experience this is the key to ensuring prompt and efficient management of patients.

While doctors need to be informed if patients are unable to take their medication or if the medication is unavailable, it is essential that nurses are kept up to date regarding medications that have been prescribed or changed. Medications may take time to prepare, such as intravenous antibiotics, or may have complex dosing schedules, such as anti-Parkinson therapies. Good communication is especially important as nursing staff are often unable to accompany doctors on their ward rounds. Shift working also means that numerous medical and nursing staff may be involved in the care of a patient during a short time period necessitating clear communication.

If a patient is designated nil by mouth (NBM) we believe the doctor's responsibility is to ensure that a proper assessment of swallowing has taken place and that appropriate alternate routes of drug administration are instituted when medications are prescribed. It is precisely because nurses operate in a protocol-driven environment that clear communication and explicit instructions are required if NBM orders are to be overridden.

The advent of dedicated medical assessment units, with staff and systems designed for a rapid turnover of patients, has already addressed some of the issues raised by this study, such as greater availability of ward-based pharmacists. Many hospitals have introduced a 'protected' drug round with dedicated nursing staff to ensure that medications are administered as prescribed.

We consider the drug history to involve more than transcribing a list from a repeat prescription slip onto a drug chart. Clear communication regarding the importance of medications will save time, effort and ensure correct drug administration.

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## Swallowing and dementia – practical solutions for a highly emotive problem?

Editor – we read with interest the review by Smith *et al* (*Clin Med* December 2009 pp 544–8). We would like to contribute to this debate with important clinical information that supports this practical approach. A recent report by Mitchell *et al* was the first prospective observational study of patients in nursing homes with dementia (n=323).<sup>1</sup> The investigators reported that over an 18-month period 85.8% of patients developed an eating problem and that the mortality in this cohort was 54.8%. Many clinicians consider dysphagia as an end-stage event in patients with dementia – nevertheless it remains a common indication for gastrostomy insertion in secondary care. How can we improve the care for patients with feeding difficulties and dementia? We have previously reported a high mortality in patients with dementia who have a percutaneous endoscopic gastrostomy (PEG) tube inserted (54% died at 30 days).<sup>2</sup> As a result of this observation we devised a pragmatic strategy to try to improve all aspects of our selection process for insertion of the tube (Table 1). By implementing this strategy and critically engaging carers in this decision-making process (as well as providing data on prognosis) we were able to show a reduction in the number of PEG tubes inserted in patients with dementia.<sup>3</sup> We believe that our data (and pragmatic approach), coupled with Smith *et al*'s