Letters to the Editor

Indeed, in the elderly, it is very difficult if not impossible to maintain feet and toenail hygiene. There are several reasons, including simple mechanical difficulty resulting from arthritic hips or lack of strength, as well as neglect due to dementia. Solving this problem in hospital currently is more difficult than it appears.

Nurses are allowed to cut fingernails untrained, but not allowed to cut toenails. In order to cut toenails they must undergo a special training course, and a few nurses have actually undergone training. In addition to this, elderly toenails are very tough and difficult to cut and so require a special tool which inevitably a minority in the wards (including geriatric) and so even if nurses are trained appropriately their expertise would be futile.

At present, the only service on offer for hospital inpatients or out-patients which is capable of remediating the problem of long toenails is the Chiropody Department. However, chiropody is only available for diabetic patients or those at increased risk of infection. There is no chiropody service for non-diabetics.

As highlighted in this case, long toenails frequently contribute significantly to fall in the elderly people and are also an important but overlooked cause for falls. Greater and more universal access to chiropody services would have significant benefit for all elderly patients and help to avoid a large number of hospital admissions.

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doi: 10.1093/ageing/afn243
Published electronically 11 November 2008

Jed Rowe—We lost one of our own

SIR—I am writing to express my deep sense of loss on hearing of the death of Jed Rowe. I am in the privileged position of having worked with Jed. I was a specialist registrar under him in 2000, and then joined the team at South Birmingham PCT and University Hospitals Birmingham, as a consultant, in 2003. I did of course know him much earlier than that—it is impossible not to have known him as both a medical student in Birmingham and an aspiring geriatrician. There was a palpable ‘buzz’ of excitement in the lecture theatre when we knew Jed was coming to talk to us. He would lumber in to the room, clothes and hair awry, whip out a pile of floppy discs (later replaced by the memory stick perpetually worn around his neck), and deliver a performance laced with humour, passion and compassion. It was never on what the lecture schedule said it would be, but that did not matter. We laughed with him, cried with him, felt the ferocity of his beliefs, respected him and loved him. It is no accident that the West Midlands produces so many geriatricians. I was extremely fortunate (everybody wanted to work with him) to spend 15 months as a specialist registrar under his tutelage. When you trained with Jed, you knew that you were in the presence of someone extraordinary. Watching him work was like watching magic. He had an intuitive way of getting straight to the problem; he provided care that was both evidence-based and innovative, all of it delivered with both a fierce seriousness and a dry sense of humour. I once watched him cry with the wife of a patient who was dying. I will never forget it, he put his arms around her and they both sobbed. He had real empathy for people, patients and relatives, and they loved him for it. The staff both respected and adored him; anybody would have done anything for Jed. He could quote virtually every reference for any paper, with the capacity to remember anything that he had read. We had some posters together at the BGS. Watching him do research and publish was to watch a genius at work. He was cutting edge, an ‘out of the box’ thinker and a trailblazer. His contribution to geriatric medicine is mammoth and cannot be overestimated.

There is a whole new generation of geriatricians as a result of him; I have watched countless young doctors arrive as physicians and leave as geriatricians as a result of 6 months working with Jed. He was one of the most popular people at BGS conferences; to him it was like a get together of old friends. There was always a ripple of excitement when his hand shot up in questions—we all knew we going to hear a ‘Jed-ism’, something either brilliant or hilarious, or both, delivered with colourful language, passion and no ‘airs and graces’.

As a consultant colleague he was the best. He helped me through the transition from specialist registrar to consultant, sitting and chatting whilst watching the ducks in the garden at his beloved Moseley Hall Hospital. He fought tirelessly for older people and the department and would do anything for his colleagues and the hospital. It is a cruel irony that one of our greatest, pioneering, geriatricians will not reach old age himself. We should feel tremendously proud that he was a member of our specialty. We are privileged to have known both the man and the doctor, and we should grieve our loss but also celebrate his life. After all, that’s what Jed would have wanted us to do.

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The effect of bedrails on falls and injury

SIR—In their helpful review of the literature on bedrails, Healey and colleagues [1] suggest that none of the retrospective surveys of falls from bed showed that injury was more likely in falls with bedrails. While accepting the intrinsic deficits of such surveys, it should be noted that our study did show such an effect [2]. I also find the data reported from the National Reporting and Learning System less reassuring than the authors: while minor head injuries were convincingly increased with falls from beds without rails, both of the subdural haematomas with falls from bed occurred with bedrails raised, and in the random selection of falls analysed, moderate or severe harm only occurred with bedrails raised [3].

Given that there is indeed a paucity of high-quality data, a report from the National Patient Safety Agency, reasonably, argued that even thinking about rolling back and forth in a bed with and without rails should convince the sceptic that bedrails prevent falls in these circumstances [4]. A similar experiment is to imagine that your bladder is full (the commonest reason for trying to get out of bed) and the lights are out and that you try to get out of bed with or without rails. There can be little doubt that the former manoeuvre is more hazardous, even if a feet-first approach is taken. Indeed, in a study using an anthropomorphic test dummy, the likelihood of severe head injury, using the injury criteria used in the car industry, was greatest during feet-first falls, probably due to deflection caused by rebound off the impacted surface, using a standard force to mimic the effect of the human body [5].

The average of 20 deaths per year from bedrail entrapment in all healthcare settings in the United States (population roughly 300 million) and of 3 deaths on average in the same settings in Britain (population 60 million) are only the reported deaths. The US Food and Drug Administration (FDA) certainly acknowledges that underreporting of such deaths is likely. A press investigation of 5 deaths and 14 injuries attributed to bedrails in a single year in nursing homes in Michigan (population 10 million; nursing home population 50,000) found that only one incident had been reported to the FDA [6]. While adherence to the bed dimensions endorsed by the FDA and by the Medicine and Healthcare Products Regulatory Authority should minimise entrapment risks, some have argued that the standards are not rigorous enough [7]. Moreover, the FDA recommends procedures for measuring and assessing gaps in hospital beds using a now commercially available cone and cylinder tool, applied using a standard force to mimic the effect of the human body [8]. Putting beds at the lowest possible height and avoiding bedrails for those who conceivably could or would try to exit the bed or manoeuvre their way into a dangerous position will be much easier.

7. Schatz WM. Comments and suggestions regarding the draft guidance for Industry and Food and Drug Administration Staff, from the document: Hospital Bed System Dimensional Guidance to Reduce Entrapment. Available at: http://www.fda.gov/ohrms/dockets/dailys/04/nov04/111504/04d-0343-c0002-voll.pdf (1 August 2008, date last accessed)

Reply

SIR—We are grateful to Dr O’Keeffe for his comments on our literature review [1] and for his important contribution.