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'.[1] This same description was used in the Department of Health's (DH) guidance document published the following year.[2]

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.[3] 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.

BENOY N SHAH
Specialist registrar in cardiology
Royal Bournemouth Hospital

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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.

JONATHAN L MARKS
Specialty trainee – rheumatology
SANDEEP MUKHERJEE
Specialty trainee – rheumatology
RICHARD G HULL
Consultant rheumatologist and clinical director
Rheumatology Department
Queen Alexandra Hospital
Portsmouth

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).[1] 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).[2] 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.[3] We believe that our data (and pragmatic approach), coupled with Smith *et al*'s