

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.

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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).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

Table 1. Strategy to try to improve all aspects of selection process for insertion of the percutaneous endoscopic gastrostomy (PEG) tube.

Standardise PEG referral form including concomitant disease
Endoscopy nurse triage and dissemination of published evidence
Gastroenterological review where necessary
Holistic and multidisciplinary approach
Advise against PEG feeding in patients with dementia
One-week waiting list policy

recent report, allows clinicians to have an evidence-based discussion about feeding with all interested parties. It also allows clinicians within the UK to have local, or at least UK, data, which are possibly relevant to their own practice. Perhaps this is a practical solution to a highly emotive problem?⁴

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Do medical patients know the name of their consultant?

Editor – We are writing in response to the letter by Pittman and colleagues in the December 2009 issue of *Clinical Medicine*

and their survey on whether patients know the name of their consultant (*Clin Med* December 2009 pp 633–4).

We are in agreement that this is an important issue. Not knowing who is in charge of your care can add to the bewilderment and anxiety surrounding a hospital admission. One solution, developed by our firm, is for the consultant to give every patient on the post-take ward round a business card with his name and contact details (including email address) (Fig 1). The card is larger than normal (12.5 cm by 7.5 cm) and we use a bigger font size (14 point) to assist the visually impaired.

We feel that this approach demonstrates strong leadership by ensuring that the patient and family are clear as to who is in charge of their care. In our experience we have found this strategy to be well received by patients and families.

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The skin in general medicine

Editor – Dhoat and Rustin reviewed an important but often neglected part of general medicine in their article (*Clin Med* August 2009 pp 379–84). We would like to add that xanthomatoses, especially xanthelasmas, are also an important marker for diabetes, propensity to coronary artery disease (CAD)¹ and gout² apart from cholestasis and hyperlipidemia as mentioned. Besides xanthelasma and xanthoma, presence of arcus juvenilis in young people (age ≤ 40 years) may also be considered as a clinical sign for premature CAD.³ Premature graying and/or balding in chronic smokers has also been shown to be associated with premature CAD.⁴ Other cutaneous signs like ear lobe crease, ear canal hair, and nicotine staining should

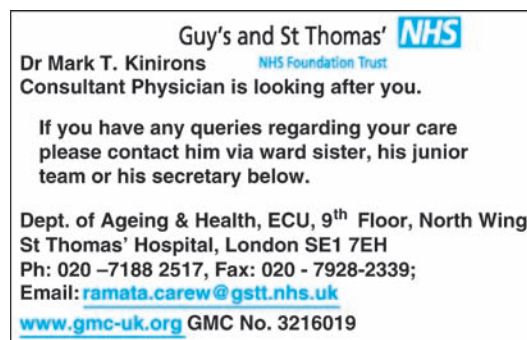


Fig 1. An example of the business card.

also be considered as valuable clinical markers of CAD.¹ Recently, hyperpigmented palm and digits of hand associated with central obesity in betel quid sellers has been shown to predispose to early CAD.⁵ There may be a clinical scenario where one sibling in the family has xanthoma, another has xanthelasma or arcus juvenilis and some suffer from CAD. The clinical implication of such a finding is that one must actively look for such signs in all family members for early identification of persons predisposed to premature CAD.

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