professional bodies. *Clin Med* 2006;6:13–5.
6 Saunders J. Institutional ethics committees: lessons from the Royal College of Physicians? *Clin Ethics* 2008;3:46–9.

Harveian Oration 2008

Editor – Sir Michael Rawlins' fascinating review of decision making in the use or approval of therapeutic interventions (*Clin Med* December 2008 pp 579–88) mentions the belief that the results of the GREAT trial of GP home thrombolysis were 'too good to be true'. Oddly, suspicions of biological implausibity are employed most often by statisticians, rather than doctors, to discount statistical hypotheses. Here, a delay of one or two hours immediately after an infarct could easily halve the benefit of thrombolysis, as was in fact observed in the study. To explain this away, an entirely imaginary prior scenario was introduced to 'pull back' the results to a more acceptable range. This example discredits rather than supports the use of Bayesian analysis. It reminds one of the bad old days when 'We set out to prove (or disprove)…' was tolerated as a preamble to a paper.

GH HALL
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In response

The phrases 'pulled back' and 'too good to be true' were deliberately put in quotes and taken from the reference. They are therefore Stuart Pocock's and David Spiegelhalter's own words. David Spiegelhalter, the doyen of Bayesian statistics, has often used this himself, as an example of the 'appropriate' use of Bayesian statistics. Hence my use in the Oration!

MICHAEL RAWLINS
Chair, National Institute for Health and Clinical Excellence

The patient–doctor partnership

Editor – It was very interesting to read Dame Margaret Turner-Warwick's excellent paper (*Clin Med* December 2008 pp 573–5). She is absolutely right that the patient–doctor partnership 'should be the cornerstone in any healthcare service'.

Having practised as a clinical haematologist for 30 years, I realised that getting the partnership between myself and my patients right was by far the most important priority in my professional life. If the doctor is really at pains to see that the partnership is working, then everything else falls into place, and the patient receives the best care available. If the partnership is working, the doctor will see to it that their colleagues at every level are people the patients feel they can trust, and the patients are usually grateful whatever the clinical outcome. Furthermore, when mistakes are made, as unfortunately they are even in the best-run institutions, the patient is far more likely to be accepting and understanding than litigious and belligerent. The fact that nowadays patients are so much better informed enhances, rather than detracts from, the partnership.

I was fortunate to work in a specialty where many of the patients had medically (as opposed to surgically) the most treatable malignancies, but the above considerations apply equally to patients with non-malignant diseases. The patient–doctor partnership is of infinitely greater importance than, for example, the type of building we practise in, new or old, polyclinic or hospital. Dame Margaret's 'solution' in her final paragraph is entirely correct – the sooner changes can be brought about to achieve this, the better. If these issues were addressed, morale would improve automatically and many of the current problems would be solved.

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Clinical & Scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

The use of aspirin and dipyridamole in the treatment of acute ischaemic stroke/transient ischaemic attack: an audit-based discussion

The National Institute for Health and Clinical Excellence (NICE) recommends combination therapy (low dose aspirin plus modified-release dipyridamole) for all ischaemic strokes and transient ischaemic attacks (TIAs), for secondary prevention. Combination therapy is recommended for two years and thereafter low dose aspirin alone.[1]

The first such audit at Withybush General Hospital in Haverfordwest was carried out in 2007 and was published as a clinical letter in this journal.[2] The practice has since been re-audited.

In the re-audit, 108 inpatients were included and data were collected on a proforma.

Eighty-nine patients (82%) presented with a first episode and 19 (18%) with recurrence. Of the 89 patients, 47 (53%) were prescribed the combination therapy and 20 (22.5%) were given aspirin only. Twelve were on warfarin, three on aspirin + warfarin, four on aspirin + clopidogrel and two on clopidogrel only. In the 2007 audit, 12% had combination therapy and 71% aspirin alone.

In the recurrent disease group, seven (37%) were on combination therapy compared to 16 (62%) in 2007 while four (21%) were on aspirin alone. Six patients were on warfarin, one on aspirin + warfarin and one on aspirin + clopidogrel.

Only three out of 54 patients on combi-

nation therapy were instructed to discontinue dipyridamole after two years.

Additionally e-questionnaires were sent to consultants and specialist registrars in elderly care medicine units throughout Wales asking the following questions:

- What antiplatelet do you prefer to use for first ischaemic stroke or TIA?
- What are the reasons if the combination of aspirin and dipyridamole is not being used?
- How long do you use dipyridamole for?

Out of 95 questionnaires only 20 (21%) replies were received, compared to 51% in 2007. Thirteen (65%) doctors used combination therapy while seven (35%) used aspirin alone following first event, compared to 22% and 30% respectively in 2007. Reasons for not prescribing combination therapy included non-inclusion in hospital formulary (1), lack of evidence (2), adverse side effects (2), and preference to commence combination therapy following a second event.

The results show a significant improvement in the use of the combination therapy following an ischaemic event between 2007 and 2008 in Withybush Hospital (Table 1). However the majority of patients (94%) were not clearly informed about treatment duration. The poor response from the geriatric consultants and specialist registrars in Wales to the questionnaires may be due to a deluge of questionnaires from other studies or could be due to the fact that the same questions were asked previously.

In July 2008, NICE issued guidance suggesting that all patients presenting with an acute ischaemic stroke should be started on 300 mg aspirin within 24 hours and that this should be for two weeks. Definitive long-term antithrombotic treatment should then follow.[3]

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Table 1. Results of the 2007 audit versus the 2008 audit.

	2007 % (n)	2008 % (n)
Number of patients	100 (101)	100 (108)
First episode	74 (75)	82 (89)
Recurrence	26 (26)	18 (19)
First event		
On aspirin	71 (53)	22.5 (20)
Aspirin + dipyridamole	12 (9)	52.8 (47)
Aspirin + warfarin	–	3.4 (3)
Aspirin + clopidogrel	–	4.5 (4)
Clopidogrel alone	4 (3)	2.2 (2)
Warfarin alone	11 (8)	13.5 (12)
Not on any agent	–	1.1 (1)
Recurrence		
On aspirin	23 (6)	21 (4)
Aspirin + dipyridamole	62 (16)	37 (7)
Aspirin + warfarin	–	5 (1)
Aspirin + clopidogrel	–	5 (1)
Warfarin only	–	32 (6)

References

1 National Institute for Health and Clinical Excellence. *Clopidogrel and modified release dipyridamole in the prevention of occlusive vascular events (TA90)*. London: NICE, 2005.

2 Al-Ameri A, Sankar V, Mohanaruban K. Do you follow National Institute for Health and Clinical Excellence guidance for transient ischaemic attack and acute ischaemic stroke? An audit based discussion. *Clin Med* 2007;7:417–8.

3 National Institute for Health and Clinical Excellence. *Stroke. Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA)*. London: NICE, 2008.

Impact of the National Institute for Health and Clinical Excellence and Social Care Institute for Excellence's dementia guidelines in a neurology-led memory clinic

Guidelines on identification, treatment and care of people with dementia were published under the joint auspices of the National Institute for Health and Clinical Excellence and the Social Care Institute for Excellence (NICE/SCIE) in November 2006.[1] These guidelines recommended that psychiatrists, particularly old age psychiatrists, should manage the entire dementia care pathway from diagnosis to end-of-life care, acting as a 'single point of referral' for all cases. Neurologists were mentioned only once in the document, in the context of commencing cholinesterase inhibitor medication, suggesting that the specialist dementia interests of some neurologists had perhaps been overlooked (no neurologist was involved in developing the guidelines), likewise the fact that a significant number of referrals to neurology-led memory clinics come from psychiatrists (>20%).[2]

Compliance with the NICE/SCIE guidelines might be anticipated to erode the number of general referrals to neurology-led memory clinics, and referrals to these clinics from psychiatrists in particular. The impact of the guidelines in a neurology-led memory service was examined by comparing referral numbers and source in the two-year periods immediately before (January 2005–December 2006) and after (January 2007–December 2008) the publication of the NICE/SCIE document.

These data (Table 1) indicate a 79% increase in new referrals seen in the second time period, but with a similar percentage of referrals from psychiatrists (23%, 21%). The null hypothesis tested was that the proportion of referrals from psychiatrists was the same in cohorts referred before