

'formulate admission diagnoses' as this may improve management of patients and facilitate earlier discharge.

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In response

The issues raised by Joseph and colleagues in response to our article are thought provoking. It appears likely that consultants are often more able than trainees in committing to a clear problem list and action plan. Reports by the National Confidential Enquiry into Patient Outcome and Death and the Royal College of Physicians highlight the dangers of trainee-led clinical decision making and also emphasise the importance of consultant review early in the acute admission.^{1,2} Our study showed that for the acute medical unit (AMU) to be effective, the consultant decision-making process should not be restricted to the post-take ward round.

Our prospective study of 2,928 patients over an eight-month period demonstrated that early consultant-led review of patients admitted to the AMU significantly reduces length of stay when compared to the consultant-led post-take ward round model. It would therefore appear intuitive that improvement in patient care will only be achieved if there is continual consultant presence on the AMU throughout the working day and early evening. It is therefore imperative that trusts continue to expand acute medicine consultant numbers. In addition AMU consultant job planning must reflect the importance of a strong consultant presence at the AMU front door.

The additional issue raised by Joseph and colleagues of how to develop acute medicine trainees in to consultant decision makers is pertinent. Our study adds weight

to the evidence that acute medical services should be consultant led.^{1,2} Within this setting, the need to allow registrars to develop decision-making skills must be balanced against the need to provide effective service provision and good clinical governance. Further study to elucidate the most effective educational strategies to deliver the acute medicine syllabus is required.

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An urgent access neurovascular clinic

Editor – We very much enjoyed reading the informative paper by Briley, Durkin and Meagher highlighting problems in gaining access to neurovascular clinics (*Clin Med* June 2009 pp 236–8). There is no doubt that the evaluation of high-risk transient ischaemic attack or minor stroke patients remains a key priority, and that investigation within the outpatient setting adds to the delay in treatment.

We have noted a large increase in the number of patients presenting with focal neurology which we believe is in part due to the national FAST campaign raising public awareness. There is reasonable evidence suggesting benefit from carotid endarterectomy in the early period after ipsilateral ischaemic hemispheric event.¹ This has led us to intro-

duce a system whereby such high-risk patients are offered same-day carotid duplex imaging during working hours.

The referral for carotid duplex is no longer dominated by neurology teams, but additionally comes from a variety of specialties, including the emergency department. This minimises delay in investigation and allows the delivery of definitive treatment more quickly to the subgroup of individuals shown to have a responsible carotid stenosis. The revision of our policy has proved to be effective, identifying candidates requiring carotid intervention earlier, hence improving outcome.¹

After considering Briley *et al's* proposed solutions, we believe having daily open-access clinics to ensure evaluation within 14 days remains inferior to that of direct in-hospital assessment as the issue of time delay introduced by outpatient management remains.² Adapting the mechanisms for the referral and undertaking of in-hospital carotid duplex scanning may limit the costs associated with inpatient stay and minimise the delays seen in the outpatient setting.¹ Such an approach, we believe, can be widely applied and should also be considered as part of the possible solution.

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In response

We thank Dholakia and colleagues for their interest in our paper. We agree there are other potential ways of providing a fast-track transient ischaemic attack (TIA) service. The small subgroup with high-grade symptomatic carotid stenosis is clearly important to identify and treat urgently; they derive unequivocal benefit from an urgent approach but represent only approximately 10% of patients with a TIA.¹ However, TIA services need to provide a more comprehensive assessment as outlined by the National Clinical Guidelines for Stroke. As a simple example, patients with atrial fibrillation will also benefit from a more urgent approach.

The advantages of a magnetic resonance (MR) imaging-based approach include:

- greater certainty of diagnosis²
- correct determination of the vascular distribution of the event. Clinicians may not be as good as they think they are in correctly determining the vascular distribution³
- a positive diffusion-weighted imaging (DWI) may also provide prognostic information in its own right⁴
- the pattern of infarction on DWI can provide clues to the cause of the event⁵
- MR angiography (MRA) can detect vascular disease at sites other than the carotid bifurcation eg vertebral and intracranial stenosis. Although not yet of proven benefit, interventional treatments for symptomatic stenoses at these other sites are now possible.

The national clinical guideline recommending urgent evaluation of high-risk TIA patients including DW-MR imaging is in line with other international recommendations.² We have now modified our service so that high-risk TIA patients are seen in a day hospital setting and undergo both MRI and MRA (when appropriate) within 24 hours of referral.

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Advances in infectious diseases

Editor – In his profound article Chris Ellis addresses what I too believe to be a myth, that ‘it is vital to complete the course of an antibiotic’ (*Clin Med* June 2009 pp 254–5). We are in good company as Harold Lambert, who was perhaps the most distinguished and wise infectious disease clinician of his generation, expressed this view in the *Lancet* in 1999.¹ The reasons for believing that most courses are too long were discussed informally in *Clinical Medicine* in the same year.² If the prevalence of bacterial resistance is directly related to population exposure to antibiotics and we are correct in our views, then to dispel this myth must be the surest and cheapest method of reducing the rate of development of bacterial resistance. A meta-analysis of the literature is unlikely to be helpful as most ‘short’ courses in published papers are themselves long in this context and stopping on recovery not allowed as an option. The studies needed to investigate this are fraught with potential

problems. They are not commercially attractive and liable to ethical and indemnity issues because of the perceived risk of under-treatment. Nevertheless they need doing but for these reasons can only be undertaken on the direction of the Department of Health or large national or international societies with the support of their governments. Should we not be pressing for them now?

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The value of the post-take ward round

Editor – The Royal Liverpool and Broadgreen Hospitals NHS Foundation Trust was one of the European Working Time Directive pilots for Skills for Health funded by the Department of Health. Their work has highlighted the benefits of clinical leadership and innovation with the creation of an acute response team for 24-hour emergency care. The learning from this has been widely shared www.healthcareworkforce.nhs.uk/liverpoolbroadgreenpilot/

In this study a number of parameters improved between 2006 and 2008 including the presence of the attending team on the post-take ward round (PTWR) (2.9% to 8%, $p=0.003$), diagnosis recorded in notes (82.7% to 88.9%, $p=0.02$) and the number of patients not receiving senior review fell from 3.2% to 0 ($p<0.001$).

The paper by Chaponda and colleagues highlights the benefits of increased consultant presence in quality of patient care and also emphasises the need for the restructuring of consultant working practices in order to deliver junior doctor training during the out-of-hours period ie outside of the traditional nine to five working day (*Clin Med* August 2009 pp 323–6).

The authors accept that by moving the PTWR to an earlier slot the night team