

**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.<sup>1</sup> 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 diagnosis<sup>2</sup>
- 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 distribution<sup>3</sup>
- a positive diffusion-weighted imaging (DWI) may also provide prognostic information in its own right<sup>4</sup>
- the pattern of infarction on DWI can provide clues to the cause of the event<sup>5</sup>
- 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.<sup>2</sup> 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.

DENNIS BRILEY  
*Consultant neurologist*

CHRIS DURKIN  
*Consultant physician*

TOM MEAGHER  
*Consultant radiologist*

*Stoke Mandeville Hospital, Aylesbury*

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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.<sup>1</sup> The reasons for believing that most courses are too long were discussed informally in *Clinical Medicine* in the same year.<sup>2</sup> 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?

CK CONNOLLY

*Retired respiratory physician  
Aldbrough St John, Yorkshire*

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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/liverpoolbroadgreen/pilot/](http://www.healthcareworkforce.nhs.uk/liverpoolbroadgreen/pilot/)

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

would be able to attend. In order to make this a reality, it requires innovative revision of consultant job plans so that they are both re-numerated adequately for their time and released from other duties during acute on call.

There is no mention of the benefits of structured consultant-led handover as a valuable learning experience during which results can be reviewed and diagnoses questioned. In addition the significant improvements in information technology that have occurred over the last few years mean that patient's results are available anytime day or night.

Junior doctors also have a responsibility themselves to ensure that they follow-up cases that they have admitted and use any changes in diagnosis as ideal topics for case-based discussions.

In conclusion we must ensure that the benefits to patients of new ways in working also extend to delivering quality training for our juniors and this may require a paradigm shift in consultant working practices.

D KENDALL  
*Project director*

R HAZARIKA  
*Assistant director*

J HARROP  
*Medical advisor*

*NHS North West Junior Doctor Advisory Team*

## 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.

### Do medical patients know the name of their consultant?

#### Introduction

When taking a history from people who had been inpatients at other hospitals we were struck by how infrequently they knew the name of the consultant who had been responsible for their care. This is a poorly documented topic, and we decided to see if inpatients in our own hospital knew the name of their consultant. Queen Mary's is a district general hospital in Kent which does not have an acute admitting unit/ward. In an average 24-hour period there are 18 medical admissions. New patients are admitted directly to any one of eight medical wards depending on the specialty and on bed availability. Care of new patients is transferred to the ward-based medical team the following working day. At the time of our survey there were 10 general and elderly medicine physicians with inpatient beds, and it was hospital policy not to have the patient nor consultant name above the bed.

The study was undertaken to determine how frequently patients knew the name of the consultant responsible for their care, and if this was influenced by length of stay or by whether the patient had met their consultant.

#### Methods

Initial data were collected in September 2006. A proforma was devised to standardise questions. Lists of medical admissions were obtained daily over eight days from the on-call medical team and the Care

Records Service (information technology system). Data of patients who were still in hospital on the afternoon of day three of their admission, provided that at least two of the days had been normal working days, were collected. This was to ensure patients had had an opportunity to be seen on ward rounds by their new team.

A month later, four medical wards were surveyed and data collected from patients who had been on the ward for at least one week.

Patients were excluded if they were over 75 years and had an abbreviated mental test score (AMTS) of less than seven out of 10, or were under 75 years with a history of confusion or memory problems.

#### Results

Of 142 patients admitted over eight days in September 2006, 82 were still in hospital on day three of their admission. Of these 27 (33%) were excluded. Of the 55 included, 20 (36%) knew the name of their consultant.

When the survey of four medical wards was conducted one month later, of 108 possible patients, 67 (62%) were excluded as they had been an inpatient for less than one week, or had an AMTS of less than seven out of 10. Of the 41 included, 19 (46%) knew the name of their consultant.

Of the total 96 patients questioned, 77 (80%) had had a documented ward round with their new consultant. Of those that had met the physician on a ward round, 46% knew the name of their consultant, compared with 21% who had not met them ( $p=0.0125$ ). Length of stay did not significantly affect whether patients knew the name of their consultant.

#### Discussion

The results of this 'snapshot' show that only a minority of hospital inpatients know the name of the consultant with overall responsibility for their care. Not surprisingly, patients were significantly more likely to know who their consultant was, if they had met them on a ward round. On ward rounds most physicians introduce themselves, but we all tend to forget names. It would seem sensible to have the consultant's name above the bed, but some trusts