

less protection against coercion to be recorded than those produced by the General Medical Council.² The principal difference between Southgate's guidelines and those of the General Medical Council is that the former do not require the researcher to offer patients a viewing of the tape. I am involved in a research project that requires the videorecording of patients' consultations and I have found Southgate's guidelines to be a useful tool when planning and executing my research. If followed closely they allow the videorecording of consultations in an atmosphere of collaboration rather than coercion.

Patients enrolled into my study are given consent forms and literature that have been designed with strict reference to Southgate's guidelines. As the primary analysis of the recordings is qualitative, generalizability is not an issue and sample size is therefore flexible. Consequently, when approaching patients (I obtain consent personally from them all), I feel under little pressure to enrol subjects into the study and patients are offered all appropriate opportunities to refuse. To date, 212 patients from a variety of practices have been asked to participate and 184 (87%) have agreed. No patient has withdrawn consent after videorecording (they can do this on the day of recording or at any time afterwards). It is my subjective impression that patients who agree to recording are not upset by the process. This accords with Pringle and colleagues, objective findings.³

I would be unhappy if patients felt pressured to take part in the project. This could reduce the validity of any research findings. I have been surprised, however, by quite how readily people agree to being videorecorded. Coercion appears to be totally unnecessary. Servant and Matheson⁴ did not prove that coercion is needed to obtain patients' consent to videorecording; they demonstrated that patients are unlikely to agree to it unless they are asked and receive an explanation verbally.

Finally, it is acknowledged that I am reporting my impressions about the use of videorecording in one small-scale research project. Perhaps before videorecording is widely adopted for use in the assessment of general practitioner registrars, we owe it to our patients to conduct a rigorous evaluation of their views on the subject.

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Acute myocardial infarction

Sir,

Dr Rickenbach raises the important issue of access to defibrillator equipment when administering thrombolytic treatments in acute myocardial infarction (letter, July *Journal*, p.387). As a postmarketing surveillance study, the Royal College of General Practitioners myocardial infarction study¹ had to be conducted in accordance with data sheet recommendations which advise that arrhythmias be 'managed with standard measures'.² When the study was launched, the incidence of so-called reperfusion arrhythmias was not known, especially after thrombolytics given in the community. Even a small increase in risk, however, could have had major implications, particularly if the administering doctor was unable to manage the problem. The study's steering committee therefore advised that doctors considering whether to participate be made aware of the value of having access to defibrillator equipment when attending patients suspected of having a myocardial infarction. As a consequence, the letters of invitation sent to all general practitioners in the United Kingdom were accompanied by a memorandum on the domiciliary use of cardiac defibrillators, written by Dr Clifford Kay and received by RCGP council in December 1990.

This document included a discussion of the advantages and disadvantages of general practitioners owning a defibrillator themselves and of the role of the ambulance services. Correspondence in the *British Medical Journal* kept the issue alive.^{3,4} Although we do not have exact data, we know that some doctors in the study who used thrombolysis did not carry their own defibrillator. We do not know if

all waited for the ambulance to arrive with resuscitation equipment before administering the thrombolytic agents. The large proportion of patients who had a cardiac arrest and who were successfully resuscitated, however, implies that most doctors were adequately equipped.

We now know that thrombolysis marginally increases the incidence of subsequent ventricular fibrillation (absolute increase about 1%), although prehospital use does not appear to enhance the risk.⁵ It is important to remember, however, that perhaps 5% of all patients with myocardial infarction have a cardiac arrest in front of their general practitioner.⁶ If defibrillator equipment is available, the chances of successfully resuscitating the patient are good (about 50%).^{6,7} Thus, irrespective of treatments given, all patients with suspected myocardial infarction should have access to defibrillator equipment as soon as possible. Given the low level of ownership of defibrillators in general practice, this will inevitably mean asking our ambulance colleagues for assistance. Hence, the recommendation of the British Heart Foundation working party that both parties attend patients with chest pain whenever possible.⁸

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