hyperpyrexia or suxamethonium apnoea) but generally we do not communicate directly. It might be argued that until now, in most cases, this has not mattered. However, our work pattern is changing and the interface between our specialties is increasing, and we may soon feel the need to be communicating with one another more often.

The interface is most obvious when considering day-case anaesthesia and surgery, and when patients are admitted on the morning of elective surgery but remain in hospital for a few days subsequently. These forms of patient management will increase in the future. There are powerful reasons why this is so. In most cases patients prefer to be at home and in all cases there are considerable financial savings if they are. Improved surgical techniques (such as laparoscopic procedures) and less toxic anaesthetic drugs, will also contribute to the continuation and expansion of these services.

It is estimated that day-case anaesthesia and surgery currently account for about 20% of all operations performed in the United Kingdom. The number of suitable procedures is increasing all the time and recently at the Royal United Hospital, Bath, I was involved in a study to look into the feasibility of day-case laparoscopic cholecystectomy. In the United States of America (where I am temporarily working) nearly 60% of all operations are performed in this manner. Here the main impetus has come from insurance companies, whose main concern is to reduce expenditure. Thyroidectomies, hysterectomies and laparoscopic cholecystectomies are often performed as day cases.

In the UK, admitting patients on the morning of surgery is uncommon but is practised for ear, nose and throat operations, particularly in paediatric patients (such as, for tonsillectomies). At the Bristol Royal Infirmary patients are seen and assessed by an anaesthetist in a pre-admission clinic. In the USA same-day admissions are far more common than in the UK. Unless special pre-operative preparation is indicated (such as before large bowel surgery) patients are seen and assessed in an outpatient clinic by nurse practitioners trained to highlight potential surgical and anaesthetic problems. Blood is taken for required investigations, and other tests (for example, electrocardiograms, chest x-rays and lung function tests) are arranged if necessary. Patients then return home until the day of their admission. Even some patients for coronary artery bypass surgery are admitted from home on the morning of surgery. Thus, in the USA, the visit by the anaesthetist the night before has been dispensed with. This is a great loss, especially as patients so often remark how much more they fear the anaesthetic than the surgery. Not only can many of the patient's anxieties and fears be laid to rest, but post-operative analgesia can also be discussed, and patients can be instructed on the use of patient-controlled analgesic pumps for post-operative pain relief.

The financial forces now at work in the UK health care system will result, I am sure, in steadily increasing numbers of day-case procedures and same-day admissions. I know that patients already turn to the general practitioners for pre-operative reassurance and advice. They will rely on general practitioners even more in the future. In order to meet this need general practitioners will want accurate and detailed information of the planned procedures. This will only be achieved if there is full and frequent exchange of information between general practitioners and anaesthetists.

I believe that patients in the UK are currently getting a 'better deal' than patients in the USA. Maintaining high standards through the inevitable changes that we face will require an increase in the cooperation and communication between our specialties. I, for one, am looking forward to this.

GEOFFREY N MORRIS

Department of Anaesthesiology
University Hospital
PO Box 238
Charlottesville, Virginia 22901
USA

## Continuing medical education programmes

Sir,
Between 1986 and 1991 the recording of clinical care in the medical records of the diabetic patients in Carney and Helliwell's study improved considerably, but the patients' biochemistry did not (March *Journal*, p.149). Between these dates, the authors had provided an extensive educational programme to the 13 practices in the Tynedale area, and practices had adopted protocols for diabetic care. The participating practices can be congratulated on their improved data but, as the study had no controls, we do not know how much of the change was the result of the programme of postgraduate education and the protocols and how much to other factors.

An effective postgraduate medical education programme is one which produces a better outcome (educational or clinical) among the participants than is found in controls who did not participate in the programme. In several settings, however, randomized controlled trials have demonstrated that continuing medical education enhances clinical performance in both intervention and control groups.[1-3] In other words, in these studies the clinicians seemed to learn nearly as much by hearing that continuing medical education was taking place as by actually taking part in it.

Conversely, improvements in patient outcome which can be shown to result from continuing medical education are relatively rare:[4,5] there is a wide gulf between improving the knowledge of the clinician and achieving something worthwhile for the patient. Continuing medical education should be evaluated by randomzed controlled trials, but sensitive outcome measures are needed to demonstrate its effects.

MALCOLM A PERKIN

Department of General Practice
St Bartholomew's Hospital Medical College
Charterhouse Square
London EC1M 6BQ

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## MRCGP examination

Sir,
I am glad that Judy Chen found the examination for membership of the Royal College of General Practitioners a stimulating and worthwhile experience (letter, March *Journal*, p.163). I feel far less happy about her suggestions for its improvement.

If the stated object of the RCGP is 'to encourage, foster and maintain the highest possible standards in general medical practice' then this would not be served by raising the pass mark of the examination. If we are serious about our stated aims, we should be moving towards opening the

doors of the RCGP, not closing them. Chen suggests that the credibility of the RCGP could be raised by a higher examination pass mark. Our credibility both within the profession and with the general public lies with the job that we do and are seen to be doing. This is independent of the pass rate of the RCGP examination.

For those who so wish, there are plenty of exclusive clubs within medicine. For the RCGP to become another in order to establish the credibility of its members would defeat the object of its existence.

DANIEL TOEG

The Caversham Group Practice
Kentish Town Health Centre
2 Bartholomew Road
London NW5 2AJ

## Counselling: scientific evidence needed

Sir,
I am interested and disturbed by the contrasts between the editorials in the March *Journal.* On page 119, Angela Coulter quite rightly calls for a 'coordinated attempt to gather scientific evidence' about fundholding. Fundholding was introduced for dogmatic political reasons by a government 'set against commissioning scientific evaluations'. In contrast on page 118, Anthony Hazzard, after reviewing studies of outcomes of counselling, says that '[studies] are unlikely to be conclusive' and sees a rationale for expanding counselling as 'people are increasingly asking for the... attention that qualified counsellors... provide'.

In *A critique of pure reason* (1781), Immanuel Kant showed that scientific reasoning cannot be applied to all things. Consideration of God and beauty requires more than analysis of the observer's sensations. In contrast, counselling is not a metaphysical concept. It is a wordly clinical process that aims to improve health, however widely defined. If studies are inconclusive, go back and try again.

Meanwhile, do not let us add another untested stress onto general practice, fuelled by supposed consumer demand. Let us wait for evidence to support counselling, not an editorial in the March 2000 *Journal* entitled 'Counselling: time for a cool appraisal'.

WAYNE LEWIS

Careg Wer Surgery
Blaenavon
Gwent

## Patients who do not receive continuity of care

Sir,
Kieran Sweeney and Denis Pereira Gray's practice is awesomely organized, and they have identified a minority of Gray's patients who buck their system of personal lists (March *Journal,* p. 133). When compared with a control group matched for age and sex those who see doctors other than the one with whom they are registered have more social and psychological problems, and are more likely to make more use of alternative sources of primary care, to fail to attend appointments, and to be in social class 4 or 5 living in a council house.

The distribution of social class in the study group was not compared with that of Gray's list as a whole, nor was the social class of members of the study group used as a matching factor when selecting controls. It is not clear therefore whether the 'syndrome' of patients for whom the personal list does not seem to work (for whatever reason) includes or is associated with low socioeconomic class, or whether low socioeconomic class is a confounding factor. It would be instructive to compare the study group with a control group matched for social class as well as age and sex.

N STUART P HANDYSIDES

34a Villiers Street
Hertford SG13 7BW

## Acute myocardial infarction

Sir,
I was interested in John Rawles' editorial concerning the general practitioner's role in early management of acute myocardial infarction (April *Journal,* p.171). He makes no mention of recommendations to advise at-risk middle-aged men to take aspirin for the classic symptoms of myocardial infarction or whether general practitioners should still carry aspirin for this purpose in the medical bag.

A 90-minute 'call to needle' time is not achievable in all cases, for even when arrival at hospital within this time limit is achieved, patients are often kept waiting. Of course, much will depend on the practice area and modes of transport available which differ widely in the United Kingdom.

If aspirin is given, does this interfere with thrombolytic therapy? If the general practitioner visits (adding to the time interval), a note will be made of the administration of aspirin, but a patient may not be able to report self-medication if an arrythmia has caused confusion.

In older patients there is the further problem of non-cardiac chest pain, for example, microvascular angina and midoesophageal diverticula, in whom exclusion of coronary heart disease is not straightforward.

Some discussion of these practical difficulties would be valuable.

M KEITH THOMPSON

28 Steep Hill
Stanhope Road
Croydon CRO 5QS

Sir,
May I suggest some possible solutions to the problems outlined by John Rawles in his excellent editorial concerning the role of general practitioners in the early management of acute myocardial infarction (April *Journal*, p.171).

I had the great satisfaction of administering anistreplase on three separate occasions during the 1991–92 trial reported by Hannaford and colleagues (April *Journal*, p.175) with successful results, but have since experienced the frustration of watching subsequent supplies of anistreplase go to waste in the surgery fridge as they passed their expiry date, unused.

Given the increasing sophistication of the ambulance services and crews, is it not more sensible that anistreplase or its equivalent is carried on all suitably equipped ambulances and that the on-call general practitioner or ambulance control centre receiving a seemingly appropriate call for help immediately notifies the other so that they can meet at the patient's home?

The degree of coordination is not as difficult to achieve as it may seem, and in fact, was achieved in two of my three cases. In addition, both of these patients had also taken aspirin as instructed on the telephone before either I or the ambulance arrived. In one of these patients the early electrocardiograph changes present before anistreplase therapy had reverted to normal by the time the patient arrived at the hospital accident and emergency department four miles away. (The electrocardiograph results were passed on to Hannaford and colleagues). All three patients survive to this day.

Such coordination would need national and local agreements, but could be cost-effective and would result in less stress for the lone general practitioner faced with a patient suffering chest pain, and in better care for that patient.