

health information generally where issues of autonomy, harm and quality of care are at stake. Cases from Australia⁴ and the United States of America⁵ and British legislation (for example, the access to health records act 1990, section 5:1a) show that there must be a likelihood of harm and that the harm must be serious.⁶

Doctors have the opportunity, however, to interpret the decision in *Martin* generously, in a way that seeks to enhance patients' autonomy, affirm their interests in personal health information, and respect their capacity to work through information which might, from a paternalistic view, seem too detrimental to disclose.

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Audit in summative assessment

Sir,
I read with interest the paper by Benett and Hayden discussing audit as part of summative assessment.¹ The establishment of vocational training for general practice was an important step in the reform process of the health system in Hungary almost three years ago. Nowadays the introduction of audit into general practice is another important task.

Developing a relevant final assessment at the end of vocational training is of fundamental importance because it can influence the work of future general practitioners. Despite continuous evaluation during vocational training in Hungary, trainees' basic knowledge of family medicine, their clinical competence and their consulting skills are tested at the end of the programme. The opinions of general practitioner trainers and clinical tutors are also considered. However, having read Benett and Hayden's paper, I think that using audit as part of summative assessment is an interesting idea. It could extend the use of audit in general practice in Hungary, with

future general practitioners using audit in their everyday work.

Implementation of such a system has several preliminary requirements, the most important of which are the establishment of specific training sessions on audit for trainers and trainees, finding relevant areas of clinical activity for auditing, and gaining agreement from those university medical schools responsible for general practice vocational training in Hungary. I thank Benett and Hayden for the idea of audit as part of summative assessment of vocational training.

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Preventing skin cancer

Sir,
In his paper discussing the prevention and team management of skin cancer in general practice, Jackson demonstrates the role of the enthusiast in providing a service akin to secondary care in a primary care setting (*February Journal*, p.97).

New initiatives are needed as skin cancer is reaching epidemic proportions,¹ albeit causing few deaths (1.6% of cancer deaths in the south west of England²). This trend is likely to continue as we are now seeing the cumulative effect of sun exposure throughout life. Longevity, foreign holidays and ozone depletion add to the problem and many mothers ignore advice to protect their children.³ The much vaunted *Health of the nation* target of halting the year on year rise in skin cancer⁴ now seems a far cry.

What should the primary health care team be doing about this problem? It is clearly not feasible for every practice to run such clinics described by Jackson as there is a dearth of suitably trained physicians. Those who are interested are not encouraged to start them as funding through the former health promotion clinic system has been stopped. This negative move caused the demise of a 'mole-check' clinic in my surgery.⁵

Clinics provide focused advice to patients, but must be supported by the written work. Some educational materials

have been produced for use in general practice including the 'play safe in the sun campaign' supported by Boots the chemists and the Cancer Research Campaign. There are, however, no British leaflets that explain how to recognize non-melanoma skin cancer. This is surprising as non-melanoma skin cancer conveniently appears on exposed skin sites, and patients in my practice had no difficulty in identifying their own basal cell carcinomas from leaflets produced by the American Skin Cancer Foundation. This foundation produces a whole range of support materials for those involved in skin cancer awareness campaigns.

There is no United Kingdom equivalent to the American Skin Cancer Foundation, but a working party has been established under Professor Rona MacKie to advise the government on *Health of the nation* targets. There are no general practitioners in this group. Primary health care teams are ideally placed to give advice focused on those at risk, without causing anxiety among the general public or diminishing the natural enjoyment of sunshine. Much can be achieved at low cost, but not without help including training, educational materials and financial encouragement to run initiatives such as skin cancer clinics.

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Videotaped consultations

Sir,
Campbell and colleagues' discussion of the acceptability of videorecording general practice consultations demonstrates a recognition, if not an acceptance, of the considerable disquiet generated both within and outwith the profession by the use of

this tool (*March Journal*, p.137). There has been much debate on patients' vulnerability to coercion into participation in recorded consultations, and the authors concede that 'inevitably some patients will feel pressurized to take part'. Herzman demonstrated that the more opportunities patients had to decline to be videotaped, the more likely they were to do so,¹ and Servant and Matheson found that the removal of coercive methods resulted in a consent rate of just 10%.²

Although quoting no consent rates, Campbell and colleagues note that since using Southgate's guidelines³ (which afford patients considerably less protection against coercion than those more recently produced by the General Medical Council⁴) consent rates have fallen. It is disappointing that, in acknowledging that patients may be coerced into videotaped consultations, there are doctors willing to take advantage of this to further their own research interests. Patients might reasonably expect that, within the intimate sphere of the consultation, their ease and security would be more vital considerations. Listed among the objectives of the study is 'to assess... the acceptability of videotape production', but nowhere in the method or results sections is there any reference to this.

A study found that only 10% of patients anticipated feeling comfortable during a videotaped consultation and, of even greater concern, just 4% anticipated being able to discuss their problem or problems fully with a trainee while being videotaped.⁵ These figures refute the suggestion that this assessment tool is generally acceptable to patients, and support the argument for the use of suitable alternative procedures, such as the recording of consultations with simulated patients, a technique of proven validity,⁶ and one which would avoid compromising real patients. It cannot be argued that patients are incapable of forming genuine opinions about videotaped consultations until they have been exposed to them, and the continued exploitation of the doctor-patient relationship in this manner is reprehensible.^{1,2,5}

It is imperative that those who portray themselves as assessors of the standards of general practitioners' competence demonstrate a degree of sensitivity to patients' feelings as acute as we would all wish to see instilled into doctors in training.

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Warfarin in stroke prevention

Sir,
Sweeney and colleagues' excellent review of the use of warfarin in non-rheumatic atrial fibrillation (*March Journal*, p.153) raises some fascinating points. In their analysis of the various studies, did they consider whether the international normalized ratio and prothrombin time ratio results were comparable between the different centres, that is, which thromboplastin reagents were used and which procedure was used to calculate the results? This question is vital for any comparison between trials comparing differing reference ranges and outcome measures.

The authors fail to comment on the success of the trial investigators in achieving their target ranges for the international normalized ratio. Although it is noted that fewer than 50% of hospital results fell within the therapeutic range (with wide therapeutic windows), it is not clear how successful any of the studies reviewed were in terms of their set therapeutic ranges. It would be interesting to know how these ranges were derived. Obviously the risk: benefit ratio will be influenced by the overall level of international normalized ratio control, and it may be that the perceived low incidence of cerebral haemorrhage resulted from 'under-warfarinization'.

The ability of primary care professionals to monitor patients on warfarin safely and effectively will depend on resources, enthusiasm and clinical skill. It has been shown that by utilizing computerized decision support, a cost-effective and clinically safe transfer of warfarin monitoring from hospital to general practice can be achieved (in a study to assess the feasibility

of using computer assisted management for the control of oral anticoagulant therapy in general practice, University of Oxford, South West Association of University Departments of General Practice abstracts, 1995). The points Sweeney and colleagues make regarding physical infirmity in elderly patients may be overcome by utilizing near patient testing to ensure that patients do not have to rely on telephone advice or on the vagaries of the postal system. Another exciting prospect is the development of home testing, whereby patients could monitor their own international normalized ratios and adjust warfarin dosing as necessary, in a similar model to that currently in practice with diabetic patients. If such initiatives can be developed and implemented, then it would be appropriate to consider the introduction of oral anticoagulation in atrial fibrillation as a health promotion strategy.

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Acute myocardial infarction

Sir,
In his editorial on the general practitioner's role in the early management of acute myocardial infarction (*April Journal*, p.171) Rawles does not include aspirin as one of the essential elements of immediate coronary care. This omission is both surprising and regrettable as aspirin has been shown to be a highly effective treatment when used alone or in combination with thrombolytic therapy for patients with acute myocardial infarction.

A collaborative overview of randomized controlled trials of antiplatelet therapy that involved almost 20 000 patients¹ (nearly all of whom were in the second international study of infarct survival, ISIS-2²) has confirmed that medium dose aspirin started immediately in patients with acute myocardial infarction and continued for one month reduces the risk of reinfarction, stroke or vascular death (that is, all deaths attributed to cardiac, cerebral, haemorrhagic, embolic, other vascular, or unknown causes) by about 29%, saving approximately 40 lives per 1000 patients treated. Moreover, long-term follow up of the ISIS-2 patients has demonstrated that the early mortality benefits of one month of aspirin are sustained for at least four years.³ The overview also demonstrated clear benefits for long-term