

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

aspirin after a previous myocardial infarction.¹

The clinical implications are that general practitioners must ensure that patients who have been discharged from hospital are maintained on medium dose aspirin (75–150 mg per day). This practice is likely to result in further substantial reductions in mortality and in non-fatal reinfarction and stroke. Since most patients can be maintained on 75 mg aspirin, the public health benefits are far larger than those achievable with pre-hospital thrombolysis.

The role of general practitioners in managing patients with acute myocardial infarction was reviewed by the British Heart Foundation working group⁴ in the light of these research results. Its report endorsed the above research findings and recommended general practitioners' early therapeutic intervention with aspirin for all patients with acute myocardial infarction, unless there is a definite history of recent trauma or surgery, bleeding diatheses or allergy (for example angioedema).

In the same issue of the *Journal* (p.175), the Royal College of General Practitioners myocardial infarction study reported on the use of pre-hospital thrombolysis by general practitioners, suggesting that such treatment is appropriate and safe. They also recommended that the 150 mg aspirin be given by mouth before treatment with anistreplase. There is no golden hour for treatment, as suggested by John Rawles, but there is certainly a golden opportunity for general practitioners to use aspirin promptly in all patients with acute myocardial infarction, especially if pre-hospital thrombolysis is being considered.

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GPs' low morale

Sir,

Following a period of poor recruitment to and low morale in general practice, the Royal College of General Practitioners has finally decided to take action (editorial, *May Journal*, p.227). McBride and Metcalfe travel over well-known ground before reaching their final conclusion — we are divided as a profession because of educational, structural and administrative factors. I would like to offer my own analysis of our demise.

General practitioners are out of touch with the economic realities of life. A long period of training in a sheltered environment, a secure job, a generous pension and an unchallenged status quo characterized by general practice sheltered monopolies and cosy cartels have rendered us insensitive to economic life.

As a profession, we have lacked strategic vision. In the 1980s it was becoming clear that the National Health Service could not continue in its existing form. Yet we had no clear vision of the future and, in fact, would not accept that change was needed at all. As a result, virtually all change has been externally imposed and has been almost universally met with professional antagonism.

We have ignored the fundamental changes that have been taking place in society. A vertical structure based on hierarchy and respect has been replaced by a more horizontal, market-driven, egalitarian structure. With the old boundaries dissolving, institutions are increasingly coming under attack. The rise of consumer awareness that demands access to the privileged knowledge that doctors once held on trust has exposed the uneasy duality between professional expertise and protective exclusivity. Even today our core values are still viewed as 'ancient virtues distilled over time'¹ — presumably handed down in some mystical primordial tradition.

The time to take action was 15 years ago, not today. But unfortunately for us, all is not lost. The leadership of the NHS has been handed to us on a plate. If we take the trouble to understand the real causes of our present situation we will realize how fortunate we really are and perhaps be able to face the future more positively.

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Reference

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Burnout

Sir,

Kirwan and Armstrong's findings indicate that part-time general practitioners are significantly less likely than their full-time colleagues to suffer from burnout, but that 'with incomes becoming more closely linked to time at work there are countervailing pressures to increase rather than decrease work commitment' (*May Journal*, p.259).

As a 39-year-old general practitioner who has reduced his practice commitment this year to three and a half days a week, I am well aware of such countervailing financial disincentives. My National Health Service income has decreased by a five-figure sum.

I have no regrets, however. I now value and enjoy the time I spend in the practice. My patients tell me how well I look — and I feel it. For the first time in years I am able to give quality time to my wife and three young children without feeling guilty that I should be working.

I am also now free to do many other things which make worthwhile use of my skills as a doctor. Within four months of beginning to work part time, I have been filmed in an educational videotape for parents of children with epilepsy, helped the local citizens' advice bureau on a health care project, started editing for a publisher a new series on family problems, participated in a local forum on domestic violence, advised a drug company about educational materials for patients with arthritis, and started research for my second book.

Although some of these activities pay handsomely, others attract no financial reward. There is more to life, however, than a fatter bank balance, and the overall benefits of part-time practice have been incalculable. Of the seven partners in my practice, I am the fourth to work part time and I wholeheartedly commend it to colleagues looking for an invigorating, fresh start.

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