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 group[4] 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.

MICHAEL MOHER

Southmead Surgery
Blackpond Lane
Farnham Common
Buckinghamshire SL2 3ER

References

1. Antiplatelet trialists' collaboration. Collaborative overview of randomised trials of antiplatelet therapy. I: prevention of death, myocardial infarction and stroke by prolonged antiplatelet therapy in various categories of patients. *BMJ* 1994; **308:** 81-106.
2. ISIS-2 (second international study of infarct survival) collaborative group. Randomised trial of intravenous streptokinase, oral aspirin, both, or neither among 17 187 cases of suspected acute myocardial infarction. *Lancet* 1988; **2:** 349-360.
3. Baigent C, Collins R. ISIS-2: 4-year mortality follow up of 17 187 patients after fibrinolytic and antiplatelet therapy in suspected acute myocardial infarction. *Circulation* 1993; **88** suppl: I291.
4. Weston CFM, Penny WJ, Julian DG on behalf of the British Heart Foundation working group. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994; **308:** 767-771.

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.

DAVID KERNICK

St Thomas Health Centre
Cowick Street
Exeter EX4 1HJ

Reference

1. British Medical Association. *Core values for the medical profession in the 21st century.* London: BMA, 1994.

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.

TREVOR STAMMERS

The Church Lane Practice
2 Church Lane
Merton Park
London SW19 3NY