of the relatives, may correlate with the patient's views more closely.[2] It would seem reasonable in a retrospective study, such as the study we undertook, to ask the opinion of those clinicians intimately involved in the final stages of their patients' care. Indeed the study reported in the July *Journal* found that in settings outside the specialist services unit the place of death was viewed as appropriate in over 90% of cases and even in the specialist services unit up to eight in 10 terminally ill cancer patients were thought to have died in an appropriate place.

A holistic approach to death and dying is indeed desirable but such an approach requires a degree of choice. At the time of the study there was no specialist palliative care support or nearby hospice facility for the inpatients of the specialist services unit. The clinicians strongly indicated that their management of terminally ill patients would have been altered had there been a nearby city-based hospice. This has since been shown to be the case with the opening of the Exeter and district hospice in 1992 on the same campus as the specialist services unit. Over the past two years there has been a decrease in specialist services unit cancer deaths for patients whose general practitioners do not have community hospital access, with the new hospice accounting for the difference observed (unpublished data). We would maintain that for a substantial group of terminally ill cancer patients, death in settings other than a busy acute specialist unit is more appropriate.

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Videotaped consultations

Sir,

In their letter (August *Journal,* p.443) Bain and MacKay raise two issues about videorecording consultations: informed consent and the effect of videorecording on patients who give consent.

We, along with the General Medical Council, believe that patients are entitled to take part in research or in the assessment of doctors if they have given appropriate informed consent. In our research using videotaped consultations in the summative assessment of registrars (trainees), we endeavoured to avoid coercion of patients by using the guidelines produced by the GMC.[1] Before these guidelines were introduced, a consent form was used that had been approved by the Joint Committee on Postgraduate Training for General Practice.

Bain and MacKay's apparent view that patients are not capable of making decisions and have to be protected from themselves is somewhat patronizing. Bain and MacKay cite Servant and Matheson in support of their arguments.[2] In this study patients were not invited to take part in videorecording but were invited to put themselves forward if they would like to be videorecorded. Therefore the response rate of 10% relates to those patients who took the trouble to present themselves as volunteers. The proportion of patients who did not care one way or the other (in our view the majority) are included in the 90% claimed to reject the use of videotaped consultations. To suggest that this study produced a consent rate of 10% is not true; no-one can consent to something unless they have been asked. These points were all made in subsequent correspondence published in the *Journal*.[3-6]

Bain and MacKay quote Herzmark approvingly.[7] We agree entirely with Herzmark that more patients will refuse consent if given plenty of opportunity and accept that this opportunity should be given. However, we think it a pity that Bain and MacKay have selectively quoted Herzmark. May we redress the balance by quoting the following from the same paper: 'no overall effect of filming was discovered when patients rated their stress after the consultation, rapport with the doctor or other aspects of the consultation'.[7]

Bain and MacKay cite a study in which they asked patients to speculate on how they thought they might feel if asked to be videotaped.[8] While speculation may be interesting, speculation is what it remains. This work was carried out in four practices, one of which had a view on the use of videorecording in training at variance with the Joint Committee on Postgraduate Training for General Practice and all training regions in the United Kingdom. Bain and MacKay's study avoided giving the patients any explanation as to why videorecording was being contemplated. They state that this was to avoid bias, but in fact asking people to agree to something without giving them an explanation produces bias.

We have recently published a paper in which we measured the effect of videotaping on patient satisfaction with consultations.[9] It was demonstrated that patient satisfaction was not affected by the presence of the videocamera. If patients had felt uncomfortable or coerced their satisfaction with the consultation would have been diminished.

Throughout the development of summative assessment we have tried to act in the best interests of patients and registrars. The purpose of summative assessment is to protect patients from doctors who are not yet competent. Our work will always place patients foremost in our considerations.

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Sir,

Bain and MacKay (letter, August *Journal,* p.443) suggest that Southgate's[1] guidelines for videorecording general practice consultations may provide patients with

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 Matheson[4] 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 study[1] 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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