this age group. Although the absolute numbers of patients involved is small and only half of those patients at greatest risk could be considered suitable candidates for receiving warfarin, the fact remains (in this practice at least), that screening for atrial fibrillation in patients aged 75 years and over would identify the majority of patients who are currently at risk of stroke and who could benefit from intervention. Such a strategy is likely to be more acceptable in terms of workload implications than a systematic audit to identify at risk patients.

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Management of opiate dependence

Sir,

The editorial by Wilson and colleagues (September *Journal,* p.454) highlighted the variability of general practitioners' contact with problem drug users. We studied the contact between problem drug users (most of whom were opiate dependent) attending a community drug team and general practitioners in Trafford, Greater Manchester.[1] Of 136 drug-dependent patients who completed a questionnaire, 119 (87.5%) were currently registered with a local general practitioner. All of them were in receipt of their methadone prescription from the community drug team rather than from their general practitioner. Of the 136 drug-dependent patients surveyed, 41 (30.1%) had been removed from a general practitioner's list at some time; 36 of the 41 believed this to be as a result of their drug dependence. This can be compared with family health services authority data for the same area which showed that a mean of 0.2% per year of all registered patients had been removed from a general practitioner's list.

If more general practitioners were willing to adopt methadone maintenance programmes for their opiate-dependent patients then perhaps a greater proportion of such patients would maintain contact with a primary care team for longer periods. This would enable both their drug dependence and presentations of ill health to be addressed in the primary care setting, with the support of secondary care services should that prove necessary.

General practice based methadone maintenance clinics comparable to that described in Wilson and colleagues' editorial are now being set up across Manchester to facilitate the provision of care for opiate-dependent patients in primary care. Perhaps as general practitioners become aware of the success of such an approach, they will be less inclined to respond to their patients' opiate dependence by striking them off their lists.

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Practice list inflation

Sir,

We read with interest the study by Robson and colleagues on the audit of preventive activities using a validated measure of patient population, the 'active patient' denominator (September *Journal,* p.463). However, that interest was sparked by our concern over the issue of list inflation. Using the data given in the study, from an original sample of 2400 patients (150 patients in 16 practices) it is likely that 453 (18.9%) should not be on the practice registers and so would not attract capitation payments. Even if the 221 patients for whom no records could be found are excluded there are 232 patients (9.7%), or, taking into account and excluding the 11, 18 and 40 people that three practices erroneously included in their original samples, 163 patients (6.8%) who should be removed from the register.

List inflation is usually measured by comparing the numbers of registered patients compiled by the family health services authorities with population estimates produced by the Office of Population Censuses and Surveys. This has rightly been criticized on the grounds that it does not take into account cross-boundary flow — patients registering with a doctor in a different family health services authority area from the one in which they live. This study shows that list inflation goes well beyond cross-boundary flow. We cannot look to the current targets for health promotion activity to help encourage practices to remove patients inappropriately remaining on their lists, as the targets are not spread across the population. There is an incentive for practices to try to achieve a fine and self-serving balance whereby they remove those 'ghosts' who make practice performance on targets look bad while making no such efforts to correct their lists for other categories of patients.

The implications for a move to a procedure based on weighted capitation for allocating prescribing budgets as advocated by the National Health Service Executive are clearly enormous, especially if, as shown in Robson and colleagues' study, list inflation varies so much between practices.

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Audiotape recordings

Sir,

In their letter, Bain and MacKay raise important issues about the use of videotaped consultations for summative assessment (August *Journal,* p.443). They point out that problems of coercion, consent and confidentiality could be avoided by using simulated patients.

Another possibility would be to use audiotape recordings. As well as being less intrusive and less expensive than videotapes, audiotapes have the advantage of preserving the anonymity of a real patient, providing names are not mentioned. Although the non-verbal aspects of a consultation are missing, audiotape recordings have been used extensively for training in communication skills and are part of the degree assessment for final year medical students at the University of Sheffield.[1,2]

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