settings range from 20% to 45%, depending upon exact case definition. O'Donnell cannot be suggesting that all patients with headaches should be referred to a specialist: such a practice would be of little benefit and carries the risk of iatrogenic over-investigation and illness reinforcement. Whatever it is that determines whether a general practitioner refers a patient presenting with the symptom of headache, it is unlikely to be the presence of that symptom alone.

SIMON WESSELY

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Sir,

I read with interest the comments of Simon Wessely regarding my letter which detailed a study of patients who presented with headache to a hospital ophthalmic casualty department (October *Journal,* p.562). He seems, however, to have misinterpreted the results and conclusions.

This was a study only of patients attending Liverpool's St Paul's Eye Hospital casualty department and thus obviously did not take into account the floating denominator. The main point that I was attempting to convey was that for patients with headache and eye symptoms or signs, if the general practitioner is considering hospital referral, an ophthalmological referral would be the most appropriate. I was certainly not suggesting that all patients with headache should have a specialist referral, and anyone with experience of general practice or the hospital service would be in agreement with this. Wessely's final point that patients with headache are only referred if there are other accompanying symptoms is a myth; there is ample evidence in the literature of such referral.

NIALL P O'DONNELL

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Warfarin therapy in primary care

Sir,

Sweeney and colleagues' review of the use of warfarin in non-rheumatic atrial fibrillation highlights the potential for anticoagulation to protect patients at risk from stroke.[1] It also mentions some of the difficulties general practitioners may have in applying such research results to their practice populations.

Subsequent correspondence from Fitzmaurice (August *Journal,* p.444) raised the question of whether international normalized ratio results from different centres can be compared. The following case history from an inner city London practice, in which I was a long-term locum general practitioner, illustrates why this point is of crucial importance not only at a theoretical level but also at a practical level.

A patient aged 82 years who was on long-term warfarin therapy, feeling unable to make the usual journey to a teaching hospital anticoagulation clinic, attended the general practice surgery for her 'blood test'. A request for an international normalizing ratio measurement was duly sent via our usual pathology services, on the same day, to a different local teaching hospital. Surprisingly, as this patient's international normalizing ratio was usually maintained at about 2.5 on 5 mg warfarin daily, the result came back at 4.6, causing me to decrease the dosage slightly. However, 10 days later, at the usual hospital clinic, the patient's international normalizing ratio had fallen to 1.5, requiring further adjustment of her treatment.

A similar scenario threatened to repeat itself several months later when this patient again attended the surgery rather than the anticoagulation clinic. The result was again high at 4.7, but on this occasion I decided to repeat the test before taking further action and took two simultaneous samples, sending one to be analysed by each hospital. The results came back as 3.1 and 4.1.

If general practitioners are to pursue the evidence-based medicine recommendations of Sweeney and colleagues and prescribe warfarin with greater frequency, it is essential that standardized laboratory investigations are directly comparable. While they are not, the pace of change in clinical practice is likely to remain slow.

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Reference

1. Sweeney KG, Gray DP, Steele R, Evans P. Use of warfarin in non-rheumatic atrial fibrillation: a commentary from general practice. *Br J Gen Pract* 1995; **45:** 153-158.

Sir,

Recent studies have emphasized the need for patients suffering atrial fibrillation to be considered for anticoagulation therapy.[1] In an attempt to respond to this we endeavoured, by computer-aided search of patients' records, to identify appropriate patients out of a list size of 10 000. Several problems became apparent.

First, more than half of the patients who were potential candidates for therapy with warfarin (28 of 49) had been seen by a hospital physician within the previous two years for a variety of reasons, without clear recommendations for such treatment being given. In view of the complexity of anticoagulation, we feel that such an identification programme should not be exclusively general practitioner led.

Secondly, even with a clear protocol and computerized patient information, it was time consuming to identify and assess the patients who should be considered for anticoagulation therapy. This is because the relative contra-indications to warfarin (for example, lack of mobility and no access to a telephone) can only be elicited from a personal assessment. While time is not a problem in a research study, it certainly is in everyday general practice.

Finally, there was concern about the risk of cerebral haemorrhage as a complication of warfarin treatment. This risk has been calculated as being three major haemorrhages per 1000 patients treated with warfarin per year.[1] This is outweighed by the prevention of 31 strokes.[1] However, for an individual patient affected by cerebral haemorrhage, and for his or her family, we feel that this may be hard to come to terms with if it is perceived as a consequence of the personal enthusiasm of the general practitioner rather than part of a formal local or national policy.

Local health authority guidelines on the identification of patients with atrial fibrillation who should be considered for warfarin therapy, with a coordinated approach from both primary and secondary care, would seem to be the best way forward.

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Reference

1. Sweeney K G, Gray DP, Steele R, Evans P. Use of warfarin in non-rheumatic atrial

fibrillation: a commentary from general practice. *Br J Gen Pract* 1995; **45:** 153-158.

General practice research

Sir,

I congratulate the *Journal* on its recent focus on general practice research, in editorials by O'Dowd and Gray (October *Journal,* pp.515 and 516, respectively) and in a discussion paper by Owen (October *Journal,* p.557). These three items cover a wide range of issues and some points require elaboration. Gray mentions the development of research general practices. Although this is to be commended, the comment is made that this development will assist 'those who have already acquired research skills'. The acquisition of research skills is a difficult task. In both New Zealand and the United Kingdom, funding for research by general practice registrars is far less than for their hospital colleagues who can fit in research with their service work. Many newcomers to research in general practice find that research is 'simple but not easy' and are often surprised at the amount of work required to produce one data-based article.

What is appropriate training for general practice research? Gray mentions both an MD thesis and membership of the Royal College of Physicians, with the implication that these could be research degrees. The latter would be of limited value in internal medicine research let alone general practice research. Although the MD has higher status in some universities than a PhD, in others the reverse is the case. The argument that an MD thesis will be better than a PhD thesis because the candidate has not been supervised is flawed. In Auckland, New Zealand, the MD is currently being reviewed because of concerns over standards. My preference is for a supervised degree (whatever it may be called) so that the candidate can experience supervision and have a benchmark on which to base his or her role as supervisor when the time comes.

Masters degrees in general practice have the potential for providing all these ingredients as an introduction to research. For candidates who proceed straight to a doctorate some course work should be essential. The content should include clinical epidemiology which would satisfy some of the concerns expressed by Owen. I have worked in Canada where clinical epidemiology was developed by David Sackett and others, and I was impressed by the family medicine and internal medicine registrars' understanding of positive predictive values in settings with a low prevalence for serious disease (that is, in general practice). Clinical discussion would often include comments such as 'what is the prior', meaning what is the pretest likelihood of disease for the symptom(s). A group of experienced clinicians can usually put approximate figures on this to help with the diagnostic process. An understanding of this is essential in making sense of general practice and enhances the science rather than destroying the art.

Thus, my preference for appropriate training for general practice research is supervised degrees with some course work in clinical epidemiology.

BRUCE ARROLL

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Patient choice of general practice

Sir,

I was interested in the study by Thomas and colleagues that assessed the outcome of making it easier for patients to change general practitioner (November *Journal,* p.581). I was a single-handed practitioner from 1948 to 1984 and in the second half of my practice life had the maximum number of patients on my list, having started from scratch. It was apparent to me that the special intimate relationship of trust between doctor and patient was the essential source of the attraction of patients to my practice rather than to neighbouring group practices.

Quite a few patients still communicate with me on a basis of friendship to this day.

NORMAN BLOCH

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Health checks for elderly patients: request for information

Sir,

We are evaluating the effectiveness of health checks for people aged 75 years and over, introduced into general practice in 1990, and want to make contact with individuals and agencies with expertise in this area. We realize that many professionals and some elderly people themselves have concerns about the appropriateness of these checks and there is little agreement on models of best practice.

We would be grateful if readers could contact us with their experiences of screening among people aged 75 years and over and with their views on good practice. The opinions of general practitioners, community nurses, health visitors, social care workers, hospital clinicians and community organizations reflecting the views of elderly people will, through this project, help redefine the current screening programme.

We can be contacted at the address below or by fax, 0171 281 8004 or e-mail, m.gould@ucl.ac.uk.

STEVE ILIFFE

MAIRI M GOULD

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Country doctors wanted

Sir,

I am researching for a book on village characters and for another on countrywomen. These books will trace the lives and experiences of some 12–20 key members of village and country communities throughout the British Isles. Along with characters such as the postman, squire, policeman, priest, butcher and baker, I wish to include a country doctor or two.

I would like to hear from or about any elderly, retired or still working doctors (men or women) with long experience of or colourful tales to tell about village and country life and changing work practices. If anyone knows such a person with interesting tales or would like to volunteer themselves, I would be pleased for them to contact me at the address below or telephone 01428 682567. All assistance will be duly acknowledged.

BRIAN P MARTIN

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