more talking (or perhaps listening) treatment and less drug therapy for emotional problems and disorders.[22] Practices up and down the country are increasingly providing these services. General practitioners and family health services authorities are becoming better informed about how to ensure a high standard of counselling. Counselling training organizers are beginning to meet the real needs of primary care counsellors through both training and continuing education. Michael Balint would surely have approved of these developments.

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References

1. Balint M. *The doctor, his patient and the illness.* 2nd edition. London: Pitman Medical, 1957.
2. Balint M, Norell J (eds). *Six minutes for the patient.* London: Tavistock Publications, 1973.
3. Kelleher D. *The general practitioner as counsellor. An examination of counselling by general practitioners.* London: British Psychological Society, 1989: 4.
4. Wood D. *The power of words.* London: Mind Publications, 1993.
5. Sibbald B, Hall JA, Brenneman D, Freeling P. Counsellors in English and Welsh general practices. Their nature and distribution. *BMJ* 1993; **306:** 29-33.
6. Kendrick T, Sibbald B, Hall JA, *et al.* Distribution of mental health professionals working on site in English and Welsh general practices. *BMJ* 1993; **307:** 544-546.
7. Sibbald B, Hall JA, Brenneman D, Freeling P. *FHSA and DHA policy regarding counselling services within general practice.* Staines: Counselling in Primary Care Trust, 1993.
8. Green A. *A feasibility study in the use of counsellors in primary care teams.* Leeds: Mind Publications, 1990.
9. Mayou R. Psychiatric consequences of road traffic accidents. *BMJ* 1993; **307:** 647-651.
10. Davis H, Fallowfield L. Evaluating the effects of counselling and communication. In: Davis H, Fallowfield L (eds). *Counselling and communication in health care.* London: John Wiley, 1991.
11. Jewell T. *Report of an evaluative study of counselling in general practice.* Cambridge: Cambridgeshire Family Health Services Authority, 1992.
12. Ball V, Corney R. The future of counselling in primary care. In: Jenkins R, Corney R (eds). *Counselling in general practice.* London: Tavistock Routledge, 1993.
13. Wiles R. *Counselling in general practice. Report 21.* Southampton: Institute for Health Policy Studies, University of Southampton, 1993.
14. King M, Broster G, Lloyd M, Horder J. Controlled trials in the evaluation of counselling in general practice. *Br J Gen Pract* 1994; **44:** 229-232.
15. Krupnick JL, Pincus HA. The cost effectiveness of psychotherapy. A plan for research. *Am J Psychiatry* 1992; **149:** 1295-1304.
16. British Association for Counselling. *Guidelines for the employment of counsellors in general practice.* Derby: British Association for Counselling, Counselling in Medical Settings Division, 1993.
17. Jenkins GC. *So you want to employ a counsellor: advice to doctors.* 2nd edition. Straines: Counselling in Primary Care Trust, 1993.
18. Henderson P. *Work specification for counsellors working in general practice.* 2nd edition. Straines: Counselling in Primary Care Trust, 1993.
19. Henderson P. *Postgraduate diploma in counselling in primary health care.* Straines: Counselling in Primary Care Trust, 1993.
20. Thomas R, Corney R. Working with community mental health professionals: a survey among general practitioners. *Br J Gen Pract* 1993; **43:** 417-421.
21. Fahy T, Wessely S. Should purchasers pay for psychotherapy? *BMJ* 1993; **307:** 576-577.
22. Mental Health Services. *Issues for local government.* London: Association of Metropolitan Authorities, 1993: 36-37.

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Practice policies for responding to patients with chest pain

A WORKING group, convened by the British Heart Foundation, has recently produced guidelines for the early management of patients with myocardial infarction.[1] The stimulus for updating previous recommendations[2] was new evidence that thrombolytic treatments produce greater benefits if given as soon as possible after onset of symptoms,[3,4] and continuing concern that much could be done to improve the care of heart attack victims.

In order to reduce the mortality and morbidity of myocardial infarction, there is a need to reduce the interval between onset of symptoms and provision of resuscitation skills, adequate analgesia, assessment and accurate diagnosis and, where appropriate, early thrombolytic therapy.[1] The working group makes the specific recommendation that patients with obvious acute myocardial infarction and no recognized contraindications should receive thrombolytic therapy within 60–90 minutes of summoning assistance.

Achieving these aims will require the development of a variety of options depending on local circumstances. General practitioners have an important part to play in determining the appropriate approach for their area. In many areas, patients with chest pain tend to contact their general practitioner before any other services.[5] The attending general practitioner makes a valuable contribution to the patient's care by providing essential diagnostic skills and the range of treatments needed for the management of myocardial infarction, including an intravenous opiate, an antiemetic drug, aspirin, atropine, lignocaine and possibly a thrombolytic agent. Although sometimes overlooked, the provision of pain relief is an easy and important way of providing patient comfort. The general practitioner's previous knowledge of the patient and his or her social circumstances, is often helpful when deciding on the appropriate management.

On the other hand, general practitioners may lack the equipment or skills to resuscitate patients who have had a cardiac arrest. These facilities, however, can be provided by frontline ambulances. It is for this reason that many practices may wish to adopt the policy of a joint response, whereby both ambulance and general practitioner respond to a call for help. A 'scoop and run' policy which involves ambulance staff bypassing the general practitioner and transporting heart attack victims to hospital as quickly as possible is, arguably, a less satisfactory option, although justified if there is likely to be a delay in the general practitioner attending.

Should general practitioners use thrombolytic therapy? For many the answer must be yes, if the target times for receiving such therapy are to be met. Geographical distance from hospital should no longer be regarded as the determining factor — many doctors in urban areas know that their patients reach hospital quickly, only to wait hours before receiving thrombolytic treatment. Each practice needs to know the likely delays in transporting their patients to hospital and the average time before receiving thrombolytic surgery after arrival. In the absence of any audit figures from the local hospital, the median times from arrival to

treatment might be assumed to be 31 minutes if thrombolytic therapy is given in the accident and emergency department, 85 minutes if treatment is started in the coronary care unit, and 105 minutes if the patients is first admitted to a general ward.[5] Other factors to be considered include the practice's ability to respond promptly, the availability of diagnostic and resuscitation equipment, and the doctor's confidence in managing the complications of myocardial infarction, which are increased slightly by thrombolytic therapy.[3,4] Consultation with colleagues working in hospital and the ambulance service should help to clarify whether it is appropriate for the practice to provide domiciliary thrombolysis. This will also provide the opportunity to discuss whether other aspects of the care of patients with myocardial infarction can be improved.

Whatever its policy with regard to thrombolysis, every practice should document how it intends to respond to patients with chest pain. The policy statement will be a valuable source of information for patients at high risk of myocardial infarction, their family and friends, newly appointed practice staff and, possibly, the relatives of on-call doctors who may answer the call for help. Some practices may also wish to include parts of the statement in their practice leaflet, including perhaps the availability of defibrillation equipment. In addition, the policy could be a powerful defence in any litigation brought by a patient or relative trying to sue a practice because thrombolytic therapy was not provided in the community; the practice would be able to demonstrate that it had considered the issue and decided that local circumstances dictated that such treatment was inappropriate. Finally, the policy can provide a useful starting point for audit of the care of patients with myocardial infarction.

There is an abundance of evidence that the numerous options for managing patients with myocardial infarction are effective.[6,7] The challenge now is to provide the mechanisms by which these therapies can be administered quickly and appropriately. The first step must be a reappraisal by every practice of its current response to patients with chest pain.

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References

1. 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.
2. British Heart Foundation working group. Role of the general practitioner in managing patients with myocardial infarction: impact of thrombolytic treatment. *BMJ* 1989; **299:** 555-557.
3. GREAT group. Feasibility, safety, and efficacy of domiciliary thrombolysis by general practitioners: Grampian region early anistreplase trial. *BMJ* 1992; **305:** 548-553.
4. European myocardial infarction project group. Prehospital thrombolytic therapy in patients with suspected acute myocardial infarction. *N Engl J Med* 1993; **329:** 383-389.
5. Birkhead JS. Time delays in provision of thrombolytic treatment in six district hospitals. *BMJ* 1992; **305:** 445-448.
6. 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.
7. Fibrinolytic therapy trialists (FTT) collaborative group. Indications for fibrinolytic therapy in suspected myocardial infarction: collaborative overview of early mortality and major morbidity results from all randomised trials of more than 1000 patients. *Lancet* 1994; **343:** 311-322.

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