

doors of the RCGP, not closing them. Chen suggests that the credibility of the RCGP could be raised by a higher examination pass mark. Our credibility both within the profession and with the general public lies with the job that we do and are seen to be doing. This is independent of the pass rate of the RCGP examination.

For those who so wish, there are plenty of exclusive clubs within medicine. For the RCGP to become another in order to establish the credibility of its members would defeat the object of its existence.

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### Counselling: scientific evidence needed

Sir,

I am interested and disturbed by the contrasts between the editorials in the *March Journal*. On page 119, Angela Coulter quite rightly calls for a 'coordinated attempt to gather scientific evidence' about fundholding. Fundholding was introduced for dogmatic political reasons by a government 'set against commissioning scientific evaluations'. In contrast on page 118, Anthony Hazzard, after reviewing studies of outcomes of counselling, says that '[studies] are unlikely to be conclusive' and sees a rationale for expanding counselling as 'people are increasingly asking for the... attention that qualified counsellors... provide'.

In *A critique of pure reason* (1781), Immanuel Kant showed that scientific reasoning cannot be applied to all things. Consideration of God and beauty requires more than analysis of the observer's sensations. In contrast, counselling is not a metaphysical concept. It is a worldly clinical process that aims to improve health, however widely defined. If studies are inconclusive, go back and try again.

Meanwhile, do not let us add another untested stress onto general practice, fuelled by supposed consumer demand. Let us wait for evidence to support counselling, not an editorial in the *March 2000 Journal* entitled 'Counselling: time for a cool appraisal'.

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### Patients who do not receive continuity of care

Sir,

Kieran Sweeney and Denis Pereira Gray's practice is awesomely organized, and they have identified a minority of Gray's patients who buck their system of personal lists (*March Journal*, p. 133). When compared with a control group matched for age and sex those who see doctors other than the one with whom they are registered have more social and psychological problems, and are more likely to make more use of alternative sources of primary care, to fail to attend appointments, and to be in social class 4 or 5 living in a council house.

The distribution of social class in the study group was not compared with that of Gray's list as a whole, nor was the social class of members of the study group used as a matching factor when selecting controls. It is not clear therefore whether the 'syndrome' of patients for whom the personal list does not seem to work (for whatever reason) includes or is associated with low socioeconomic class, or whether low socioeconomic class is a confounding factor. It would be instructive to compare the study group with a control group matched for social class as well as age and sex.

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### Acute myocardial infarction

Sir,

I was interested in John Rawles' editorial concerning the general practitioner's role in early management of acute myocardial infarction (*April Journal*, p.171). He makes no mention of recommendations to advise at-risk middle-aged men to take aspirin for the classic symptoms of myocardial infarction or whether general practitioners should still carry aspirin for this purpose in the medical bag.

A 90-minute 'call to needle' time is not achievable in all cases, for even when arrival at hospital within this time limit is achieved, patients are often kept waiting. Of course, much will depend on the practice area and modes of transport available which differ widely in the United Kingdom.

If aspirin is given, does this interfere with thrombolytic therapy? If the general practitioner visits (adding to the time interval), a note will be made of the

administration of aspirin, but a patient may not be able to report self-medication if an arrhythmia has caused confusion.

In older patients there is the further problem of non-cardiac chest pain, for example, microvascular angina and midesophageal diverticula, in whom exclusion of coronary heart disease is not straightforward.

Some discussion of these practical difficulties would be valuable.

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Sir,

May I suggest some possible solutions to the problems outlined by John Rawles in his excellent editorial concerning the role of general practitioners in the early management of acute myocardial infarction (*April Journal*, p.171).

I had the great satisfaction of administering anistreplase on three separate occasions during the 1991-92 trial reported by Hannaford and colleagues (*April Journal*, p.175) with successful results, but have since experienced the frustration of watching subsequent supplies of anistreplase go to waste in the surgery fridge as they passed their expiry date, unused.

Given the increasing sophistication of the ambulance services and crews, is it not more sensible that anistreplase or its equivalent is carried on all suitably equipped ambulances and that the on-call general practitioner or ambulance control centre receiving a seemingly appropriate call for help immediately notifies the other so that they can meet at the patient's home?

The degree of coordination is not as difficult to achieve as it may seem, and in fact, was achieved in two of my three cases. In addition, both of these patients had also taken aspirin as instructed on the telephone before either I or the ambulance arrived. In one of these patients the early electrocardiograph changes present before anistreplase therapy had reverted to normal by the time the patient arrived at the hospital accident and emergency department four miles away. (The electrocardiograph results were passed on to Hannaford and colleagues). All three patients survive to this day.

Such coordination would need national and local agreements, but could be cost-effective and would result in less stress for the lone general practitioner faced with a patient suffering chest pain, and in better care for that patient.

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Sir,

As arrhythmias occur when thrombolytics are administered, it is advised by Rawles (editorial, *April Journal*, p.171) and by Hannaford and colleagues (*April Journal*, p.175) and elsewhere<sup>1</sup> that every doctor carrying thrombolytics outside hospital should also carry a defibrillator. I was not aware of this in 1992 when I considered participating in Hannaford and colleagues' study and it is not yet made clear in published drug advice.<sup>2</sup> I would ask Hannaford and colleagues how many doctors in their study relied on the ambulance defibrillator rather than their own machine, and if any doctors administered thrombolytics in the absence of a defibrillator.

If reperfusion can precipitate arrhythmias then other drugs that relieve ischaemia might produce arrhythmias during myocardial infarction. I would value further information on this, because drug administration can often be delayed until defibrillation facilities have arrived.

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### References

1. Weston C, Penny W, Julian D. Guidelines for the early management of patients with myocardial infarction. *BMJ* 1994; **308**: 767-771.
2. British Medical Association and Royal Pharmaceutical Society of Great Britain. *British national formulary* 29. London: BMA and The Pharmaceutical Press, 1995.

### Skin biopsies in general practice

Sir,

It is encouraging to learn that Deverell and colleagues found that general practitioners made important errors (malignancy unsuspected or misdiagnosed prior to histology) in only 13 of 722 skin biopsy specimens submitted to a histopathology laboratory (letter, *April Journal*, p.216). I welcome their conclusion that 'skin bi-

opsies can be competently performed by general practitioners'.

However, I would like to take issue with the authors on their choice of gold standard to assess that competence — the accuracy of clinical diagnosis compared with histological diagnosis. I would argue that the case for biopsies by general practitioners is much stronger than they suggest and that they have minimized it with an inappropriate choice of gold standard and subsequent failure to consider the reasons why general practitioners select skin lesions for biopsy.

I wonder if the authors have considered that the skin lesions in question would never have been excised and submitted for histology unless the diagnosis was in doubt. I speculate that their laboratory requisition form contains a section marked 'clinical diagnosis' and suspect that their client general practitioners were simply too well mannered to write 'If I knew that, I would not be sending you this specimen'.

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### Effects of anorexia nervosa on bone density

Sir,

As a recovering anorexic I would like to draw general practitioners' attention to the often overlooked effects of amenorrhoea on bone density. After over 10 years of amenorrhoea I was eventually given a bone scan which showed that I had only 47% of the bone density expected for my age in my femur, and 70% of that expected in my spine. As this was discovered before I had reached my peak bone mass I have managed, through calcium supplements, to replace some of that lost and I now have yearly bone scans.

Studies at Kings College Hospital, London show that if amenorrhoea lasts for more than six months there will be some permanent effects on bone density (newsletter for the Eating Disorders Association, 2 August 1991). Likewise, Freeman and Newton report that their studies 'would indicate that it is an extremely serious problem, one which has been markedly under-estimated in the past' and that 'the degree of bone loss is considerably more than that which occurs in post-menopausal women, that it may occur very early in the disorder and may

not be reversible'. They also say that 'the consequence of [this] is that young anorexics, even after recovery, may be at high risk of the type of fractures more commonly a consequence of old age' (newsletter for the Eating Disorders Association, 2 June 1992).

With more awareness of the high risk of osteoporosis in anorexia nervosa it might be possible to reverse, or at least to halt, this dangerous extent of bone loss.

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### Useful addresses

The Eating Disorders Association, Sackville Place, 44-48 Magdalen Street, Norwich, Norfolk NR3 1JU.

The National Osteoporosis Society, PO Box 10, Radstock, Bath BA3 3YB.

### Postmortems in patients' homes

Sir,

In my article on how John Parkinson performed the postmortem on Sir James Mackenzie I told how Sir James had advocated the value of having a small postmortem set for autopsies in patients' homes.<sup>1</sup> It later happened that his own heart was removed by Parkinson (later Sir John Parkinson) in the bathroom of Sir James' London flat.

I have now become very interested in the question of whether general practitioners did actually undertake postmortem examinations in the homes of their patients. If so, such examinations would probably have been limited to removing one organ such as a kidney or the heart. Information on this subject is difficult to obtain, and I would be most grateful if anyone could tell me of their experience of, or of anything they know about, this subject. My telephone number is 01424 813228, should that prove easier than sending me a letter.

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### Reference

1. Hollman A. How John Parkinson did the postmortem on Sir James Mackenzie. *Br Heart J* 1993; **70**: 587-588.