

will probably always be able to exceed the resources allocated, and therefore the difficult but necessary campaign will continue. Our duty must include a contribution to hospital management to improve efficiency and reduce waste. The help and influence of the BMA in this would be welcome and should be developed.

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- 1 Samuel O. Fundholding practices get preference. *BMJ* 1992; 305:1497. (12 December.)
- 2 Delamothe T. Hospitals cut elective surgery in attempt to stay solvent. *BMJ* 1992;305:1451. (12 December.)

EDITOR.—Tony Delamothe's news item about cuts in elective surgery refers to examples in Southend and Basildon and Thurrock.<sup>1</sup> He suggests two main explanations for this situation. Firstly, he suggests that purchasing authorities may be holding money back. This is not the case in these examples as both district health authorities are overcommitted. Secondly, he suggests that sufficient money does not exist to meet the demand for services. The two authorities are a total of £14m under the weighted capitation target, and this therefore provides at least part of the answer. The health authorities have expressed concern that a gap of this size still exists and have little expectation of receiving all the extra money until well after 1995-6.

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- 1 Delamothe T. Hospitals cut elective surgery in attempt to stay solvent. *BMJ* 1992;305:1451.

## American view of NHS reforms

EDITOR.—Having studied the NHS in the past and having personal experience in primary care, geriatrics, and administration in the United States, I was eager to see the effects of, and gather reactions to, the recent reforms in Britain. Last November I accompanied and interviewed physicians, nurses, social workers, therapists, and the public in five health districts.

What I found was that the time honoured ways in which the British provide primary care and care of elderly people, though they vary by individual, seem well organised and are of high quality, cost conscious, and far ahead of those in the US. The providers, however, were uncomfortable about erosions of these prior achievements by recent government initiatives.

There was agreement that the primary motivation for the new changes in the NHS and social services has been cost containment. American health care models are being introduced, particularly competitive models, case management, quality measurement, and data systems to monitor the changes. There was total agreement that such changes are detrimental, taking time away from patient care and adding costs for both management staff and data systems that they thought were not needed.

It is intriguing that the US was chosen as a model when its total health costs per person per year are nearly three times Britain's and rising more rapidly. Moreover, 87% of the American population wants major change in its "non-system." Certainly, the US has some interesting demonstration projects, now well publicised, but most of those have not yet been thoroughly studied or found generally applicable.

If most prior complaints about the NHS related to underfunding (for example, the wait for elective surgery, run down facilities, crowded surgeries, etc) it would have been more prudent to increase funding of direct services rather than spend as

much to change whole systems. On top of that is the cost of rebuilding what existed previously if the reforms prove a failure as costs escalate. If you are interested in total health costs the shift from public expense to private expense (including profits)—as in the US—is merely a subterfuge.

But most puzzling to me, given the apparently widespread opposition to—and outright anger about—the reforms, is the near lack of organised opposition to them. Is the famous "tight upper lip" interfering with what should be done? Perhaps what the British should copy from the US is not how to fragment and overbureaucratise a health system but the ways in which many of us have learnt to build movements opposing the government when it goes wrong.

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## Antithrombotic treatment and atrial fibrillation

EDITOR.—Gordon D O Lowe's editorial<sup>1</sup> and Claes Gustafsson and colleagues' paper<sup>2</sup> on atrial fibrillation and antithrombotic treatment prompted us to examine our practice and consider the implications of treatment. This is particularly relevant in the light of the aims of *Health of the Nation*.<sup>3</sup>

We work in a training practice with a list of 13 250. From our computerised records we identified patients with a recorded diagnosis of atrial fibrillation and those who are currently receiving digoxin. We have reviewed the notes of the 76 patients with atrial fibrillation (0.57% of the practice population).

Fifty one of the patients were under 80, of whom 11 had either medical or social contraindications to use of anticoagulant treatment. Of the remaining 40 patients, seven were already receiving anticoagulant treatment. This left 33 patients, 31 of whom had not had a stroke. Nine of this group had coexisting heart failure or hypertension. With an annual rate of stroke of 5% we would expect a rate of stroke of 1.55 patients a year in this subgroup of 31 patients. A reduction of the rate with anticoagulation would reduce this to 0.52 cases a year. With a complication rate of 0.3% this would be increased to 0.61 cases a year. This is a reduction of almost one stroke a year in our practice. The Medical Research Council's trial in 1985 reported that to prevent one stroke 850 patients with mild to moderate hypertension of a similar age must be treated for one year.<sup>4</sup>

We conclude that practices setting up programmes for the primary prevention of stroke should identify patients with atrial fibrillation. Treating this small group of patients could produce a similar reduction in the number of strokes to that seen in treating a much larger group of patients with mild to moderate hypertension in the practice.

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- 1 Lowe GDO. Antithrombotic treatment and atrial fibrillation. *BMJ* 1992;305:1445-6. (12 December.)
- 2 Gustafsson C, Asplund K, Britton M, Norrving B, Olsson B, Marke L-A. Cost-effectiveness of primary stroke prevention in atrial fibrillation: Swedish national perspective. *BMJ* 1992; 305:1457-60. (12 December.)
- 3 Secretary of State for Health. *The health of the nation*. London: HMSO, 1991. (CM1523.)
- 4 Medical Research Council. MRC trial of treatment of mild hypertension: principal results. *BMJ* 1985;291:97-104.

EDITOR.—We recently looked at the current treatment of patients with atrial fibrillation in a large general practice and were therefore interested in Gordon D O Lowe's editorial.<sup>1</sup> Our findings reflect

the previous uncertainty about the benefits of anticoagulation: 18 of 50 patients were taking warfarin, but there were no great differences between the patients taking and not taking the drug. What are the implications for general practice of the new evidence of benefit?

Atrial fibrillation is common in general practice. Applying the prevalence found in the Framingham study<sup>2</sup> to Britain suggests that a practice with 10 000 patients of average age distribution has about 80 with atrial fibrillation. It would be helpful to have clearer guidance on the main question for general practitioners: which of these patients should be referred for cardiological assessment with a view to anticoagulant prophylaxis?

Should we follow Claes Gustafsson and colleagues' suggestion that patients aged 80 or over should be excluded because of their increased risk of cerebral haemorrhage when taking anti-coagulant drugs?<sup>3</sup> There seems no point in referring patients with definite contraindications to anticoagulant drugs. Also, the late Professor J R A Mitchell questioned the point of offering lifelong prophylactic treatment with a degree of inconvenience and danger to people who are generally risk takers in other aspects of their lives (personal communication). It certainly seems important to explore patients' attitudes to such treatment when considering referral.

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- 1 Lowe GDO. Antithrombotic treatment and atrial fibrillation. *BMJ* 1992;305:1445-6. (12 December.)
- 2 Wolf PA, Abbott RD, Kannel WB. Atrial fibrillation as an independent risk factor for stroke: the Framingham study. *Stroke* 1991;22:983-8.
- 3 Gustafsson C, Asplund K, Britton M, Norrving B, Olsson B, Marke L-A. Cost effectiveness of primary stroke prevention in atrial fibrillation: Swedish national perspective. *BMJ* 1992; 305:1457-60. (12 December.)

## White coat hyperglycaemia

EDITOR.—Lesley V Campbell and colleagues report on "white coat hyperglycaemia,"<sup>1</sup> but their study lacks the mainstay of modern management of diabetes—namely, the glycated haemoglobin concentration at the time of consultation. This is the best method of assessing glycaemic control, and a contemporary value must be available at the visit to the clinic.

My clinic asks patients to have a blood sample taken about 10 days before their consultation, usually at their general practitioner's surgery or at the hospital. The blood is then sent for analysis so that the result is available at the time of consultation. Up to date results are also available on a laptop computer at the clinic's reception desk so that any laboratory values measured the previous afternoon are available to the doctors. Thus for every patient at every visit the haemoglobin A<sub>1c</sub> concentration is available and both the doctor and the patient know that the value will be discussed.

I take issue with the authors' assurance that falsification or optimisation of home blood glucose monitoring is rare. In my experience it is relatively common—done either on purpose or inadvertently—with patients producing a record of home tests, often alternating values of 4 and 7 mmol/l, which are grossly discrepant with their haemoglobin A<sub>1c</sub> concentration. This sort of discrepancy suggests to me optimisation of the home results rather than white coat hyperglycaemia. I place little value on the blood glucose estimation at the clinic when records of home blood glucose monitoring and a recent haemoglobin A<sub>1c</sub> concentration are available.

Campbell and colleagues' study also highlights the obvious points that you should carefully select