support from the British Heart Foundation, the Association of Anaesthetists, and the College of Anaesthetists, has developed a comprehensive manual, a set of slides, and assessment materials and has begun running educationally sound standardised courses. A national office has been established at the British Cardiac Society, with a full time coordinator to oversee the development of this programme.

The advanced cardiac life support course in Manchester has been granted temporary recognition by the Resuscitation Council to the end of this year. It is hoped that Manchester, along with Barts, Oxford, Colchester, Edinburgh, Weston Super Mare, etc, will then run the Resuscitation Council's advanced life support courses, particularly as all centres have had an input into the development of these courses.

Advanced trauma life support in Britain, which is supervised by the Royal College of Surgeons of England, has been successful because clinicians have been prepared to accept one course with one manual advocating one style of practice. The success or otherwise of advanced cardiac life support will depend on similar acceptance of one course. It seems reasonable that the Resuscitation Council (UK), which has set guidelines for resuscitation that have been accepted nationally since 1984, should be the supervisory body. The interests of patients suffering cardiorespiratory arrest are more important than the self interest of any centre providing a course.

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Chloroquine poisoning

EDITOR,—The report on the Hammersmith grand round on chloroquine poisoning does not give the blood concentrations of chloroquine in the patients.[1] In addition, the authors do not fully emphasise the role of the activated charcoal given to both the patients who survived. We report a case in which a potentially lethal concentration was recorded but the patient survived without needing inotropic support or infusion of diazepam.

A 33 year old woman presented to hospital 85 minutes after ingesting 40 tablets (8 g) of chloroquine sulphate. She had vomited once before reaching hospital. When she was admitted to the accident and emergency department her temperature was 34·4°C, pulse 80/minute and regular, and blood pressure 84/46 mm Hg. The initial plasma chloroquine concentration was 2·49 mg/l. Electrocardiography showed sinus rhythm with a prolonged PR interval and mean QRS interval of 0·16 s and 0·15 s respectively. The patient underwent gastric lavage (no tablets were identified), and then 50 g of activated charcoal was administered directly into the stomach. She was transferred to the intensive care unit, where her cardiac rhythm, level of consciousness, and renal output were all preserved. Inotropic support, sedation, and ventilation were not required. An additional dose of 25 g of activated charcoal was given 13 hours after she took the chloroquine. She recovered completely and was discharged after three days.

In a previous study a chloroquine concentration ≥ 8 mg/l was associated with 100% mortality,[2] but it is not stated whether the concentrations were measured in plasma or whole blood. This is important as in normal subjects chloroquine is selectively concentrated in red cells by a factor of 3-10,[3] and Stead and Moffat determined that death may occur when plasma chloroquine concentrations are above 2·25 mg/l.[4] The concentration in our patient had fallen to 1·5 mg/l at 4 hours 45 minutes, when studies of therapeutic doses in volunteers would have predicted a further rise,[5] and to 0·9 mg/l (less than half the initial value) by 6 hours 30 minutes. In the retrospective review quoted, reliable predictors of death were ingestion of ≥ 5 g chloroquine base, a systolic arterial pressure < 80 mm Hg, and a mean QRS interval 2 Our patient fulfilled all three criteria.

Activated charcoal is effective in volunteers given therapeutic doses of chloroquine.[5] It not only prevents absorption but also increases the elimination of many drugs; chloroquine is well adsorbed by activated charcoal. The experience with activated charcoal in our case and in the two reported by K Meeran and colleagues[1] confirms recommendations on the use of activated charcoal, which were based on animal studies and studies in volunteers of chloroquine overdosage and pharmacokinetics.

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Citizens' advice in general practice

EDITOR,—Providing citizens' advice in general practice can address considerable unmet needs in the community and secure for vulnerable, sick, and disabled people their rights and entitlement to benefits from the social security system, which clients may perceive as remote, unhelpful, and unfeeling.[1]

In Sandwell a pilot project was set up for six months last year, in which an adviser on welfare rights from the housing department was based for two sessions a week in a health centre serving about 15 000 people; each session lasted one and a half hours. Fifty two clients received advice, being seen on a total of 325 occasions. Eighteen clients received lump sum payments totalling £10 393. Recurring benefits for these clients were projected at £14 358 for 1992-3. The outcome of 64 claims or appeals was not notified to the worker. Financial returns were two and a half times those gained by clients seen as part of the adviser's general caseload. The project was considered to be an outstanding success financially for clients. The average number of contacts per client (6·25) suggested that these clients had more complex problems than clients seen as part of the adviser's general caseload, furthering the view that health centres could be a valuable site for picking up unmet needs.

Subsequently, the health authorities commissioned an advice service on welfare rights from the citizens advice bureau, involving two full time equivalent advisers in four general practices in Sandwell. In the first six months 985 inquiries were made by 583 patients. Altogether £20 933 in benefits was secured for clients, about 60% in lump sum payments and 40% as continuing income. Counselling was required for debts totalling £226 641.

This service can alleviate ill health caused by poverty and the poverty of patients and carers caused by ill health (for example, by arranging disability benefit, mobility allowance, attendance allowance, or compensation for an industrial injury). Primary care premises are generally regarded as places of trust and confidentiality and offer opportunities for large numbers of people to seek and receive advice; they could be used in addition to traditional centres giving advice on benefits.

Treasury ministers are scrutinising some of these benefits. We are concerned that as we secure clients' rights and entitlements under the current social security system our success may lead to a redefinition of these rights and further rationing of benefits to the most impoverished, disabled, and disenfranchised people in society. We hope that our professional organisations will resist any further erosions by the government of the quality of life of these groups of people.

Sandwell health authorities are committed to developing welfare rights services in primary health care settings as a contribution to Sandwell's strategy against poverty.

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Videotaping general practice consultations

EDITOR,—We agree with the concerns expressed by A G Baird and J C M Gillies about videotaping of real consultations.[1] Patients' views on the acceptability of videotaping live consultations with trainee general practitioners are of paramount importance. To ascertain these a questionnaire survey was conducted by an independent researcher (JEB). The questionnaire, designed to eliminate bias, was distributed for self completion to 100 patients randomly selected from each of the waiting areas of a training and a non-training practice.

The χ^2 test was applied to the null hypothesis—that most patients would not feel under pressure to participate in a videotaped consultation, would feel comfortable during it, would be able to forget that it was being recorded, and would not feel inhibited by the camcorder. There was no significant difference in the results obtained from the two practices.

Of the 179 patients who completed the questionnaire, 97 said that they would not feel under pressure to participate in a videotaped consultation if asked while 82 said that they would. Forty six thought that they would feel comfortable during the consultation but 133 thought that they would feel uncomfortable. One hundred and thirty three said that they would find it either difficult or extremely difficult to forget that the consultation was being recorded. Forty seven thought that they would be able to discuss fully their problem(s) with the trainee. The null hypo-thesis was therefore rejected.

Though assessment of consulting skills is desirable, there is considerable disquiet among patients, local health councils, and the medical profession. Many are justifiably concerned that some patients

will feel obliged to participate in consultations during which the presence of the camcorder will promote inhibitions and unease. Doctors might become desensitised to video recorders in the surgery, but patients, for whom the consultation is an intensely personal experi-ence, cannot be expected to be indifferent. Trainers who have taken comfort from the concept of informed consent should be concerned that about half of the respondents in this study would feel under pressure to agree to participate in recorded consultations, and also by a recent study in which 69% of patients admitted to not reading their consent form before signing it.[2]

We submit that videotaping of live consultations is unacceptably intrusive and an abuse of the doctor-patient relationship. We recommend that this mode of assessing trainees should be stopped so that patients are not compromised and to prevent damage to the profession's reputation.

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Canvassing the health care industry

EDITOR,—Allyson M Pollock's editorial on the future of health care in the United Kingdom refers critically to a report by Andersen Consulting and Burson-Marsteller, stating that management consultants are not constrained by study design "since they describe an overall response rate of 27·5% as excellent."[1]

Our aim was to canvass all sectors of the health care industry, ranging from policymakers to patients. To obtain a wide range of opinions we canvassed groups such as medical associations, associations of pharmaceutical manufacturers, and health authorities. Other people important in the provision of health care, such as practising doctors, were included.

We send out 10 000 in depth questionnaires, and over 2700 were completed. No incentive was offered other than the opportunity to contribute to the study and the value of the findings. Typical response rates to surveys of this nature in the commercial setting are 10-15%. Thus the response rate of 27·5% fully supports the importance of this study to the groups canvassed.

The responses were not weighted owing to the difficulty of correctly weighting the figures to give an overall European view. Is the opinion of a doctor in Sweden more or less indicative of the future development of health care in Europe than the view of an academic in Spain? We decided that it was better to leave the results in their raw form and allow the readers to draw their own conclusions. Key statistics were broken down by country, and in some cases by type of respondent.

The response rate by country was led by the United Kingdom, Spain, and France, with each returning over 4000 completed questionnaires. Responses across the 10 countries surveyed came mainly from doctors (28%), policymakers (15%), and buyers of health care (12%); manufacturers of pharmaceuticals and equipment, academics, industry observers (media and patient groups), and hospital directors accounted for the remainder.

A report of this depth and scope cannot cover every issue or opinion generated. Together with the expert panel, the report's authors covered topics thought to be of paramount interest to readers involved with the many aspects of provision of health care throughout Europe. We believe that this report is the largest of its kind conducted in Europe and offers a valuable insight into the predictions of providers of health care and their suppliers over the next five years.

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Control of communicable disease

EDITOR,—It is encouraging to see the widespread support, including that from Scotland,[1] in the correspondence stimulated by the paper on control of communicable disease of which I was an author.[2] Two specific points merit response.

Firstly, E Kangesu fails to distinguish between regions and regional health authorities.[3] Regional health authorities are under review and might well be changed. Intermediate tiers between the Department of Health in England and both purchasers and providers will, however, continue to be needed and will be potentially valuable for the control of communicable disease.

The Association of Medical Microbiologists clearly agrees broadly with me and my colleagues.[4] It concurs with our view that the resources for controlling outbreaks sit with providers in the current arrangements. Unfortunately, those resources will decrease if purchasers fail to recognise the need for their use. Hence our recommendation that responsibility for controlling outbreaks should rest in a location with equal access to purchasers and providers.[2]

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Treatments for tinnitus

EDITOR,—Linda M Luxon is right to attempt to dispel doctors' therapeutic nihilism regarding tinnitus.[1] We were disappointed, however, by the guidance she offers on the specific indications for psychological treatments.

One of the commonest symptoms associated with tinnitus is anxiety, for which Luxon advocates benzodiazepines. Because tinnitus is a chronic condition the risks of dependence on tranquillisers is high. Because of current litigation on this issue, we were especially surprised to see this recommendation supported by reference to an article on the medicolegal aspects of tinnitus.[2]

Although it may well be effective,[3] cognitive therapy is not offered in most ear, nose, and throat clinics. The main reasons are cost and accessibility, as cognitive therapy for tinnitus requires about 10 hourly sessions with a trained therapist. There are simpler and cheaper treatments which are none the less effective. Relaxation therapy varies in its exact nature, but generally six to eight individual 30 minute sessions are sufficient.[4] Relaxation is simple and can be administered by nurses, occupational therapists, and general practitioners after minimal training.

Luxon does not offer specific guidelines on prescribing tricyclic antidepressants. In our opinion patients with tinnitus should be routinely screened for depressive symptoms with a standardised self report questionnaire. Depressed patients should be treated with an antidepressant such as dothiepin, which has mildly sedative properties that can help with insomnia and anxiety as well. The evidence is not good that tricyclic antidepressants vary in their potential to treat depression in patients with tinnitus. There may be other indications for antidepressants in tinnitus, as in pain therapy, but they are unknown.

Who should be referred to a psychiatrist? Patients suffering from persistent anxiety after treatment with simple relaxation may be suitable for cognitive therapy. Patients suffering from depression that is resistant to treatment and certainly those with suicidal ideas (which should be actively sought) need referral. Patients whose personal and social handicap is disproportionate to their physical morbidity also merit assessment.

All these treatments can be provided by the liaison psychiatry team. This is yet another area in which close liaison between a general hospital's psychiatric team and other specialties can help patients who have both physical and psychological problems.

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Acute circulatory support

Noradrenaline may preserve renal function

EDITOR,—We endorse Matthew J Barnard and Stephen P K Linter's "stepwise" approach (volume repletion, correction of hypoxaemia and anaemia, use of adrenergic agents to maintain cardiac index) in the management of shock.[1] Invasive cardiovascular monitoring is mandatory and the therapeutic goal is optimisation of oxygen transport. Resistant hypotension, with low mean arterial pressure and low systemic vascular resistance may require treatment with noradrenaline. There are concerns ("noradrenaline . . . particularly compromises renal blood flow"[1]) regarding its effect on renal function but we believe that its role in the particular pathophysiological setting of septic shock warrants further comment. As well as preventing fatal circulatory failure, using noradrenaline may also preserve renal function in selected patients.

How does noradrenaline affect renal function? Infusion into normotensive and hypertensive dogs causes decreased renal blood flow with increased renal vascular resistance.[2] Filtration fraction and glomerular filtration rate are maintained, suggesting a greater effect on efferent arteriolar tone. Similar effects occur in normotensive and hypertensive humans.[2] An animal model of reversible acute renal failure induced by noradrenaline exists; this requires infusion of noradrenaline directly into the renal artery. Extrapolation from such experiments to clinical settings may be inappropriate.