

istration is focusing on this in its "health in the next millennium" work programme, as is the Medical Research Council in its Gambia project, and the Liverpool School of Tropical Medicine now incorporates non-communicable diseases into its diploma courses. We suggest that the speciality of tropical medicine should shift towards a broader speciality of "health in developing countries," with the multidisciplinary inputs that the authors recommend, rather than be subsumed into infectious diseases.

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1 De Cock KM, Lucas SB, Mabey D, Parry E. Tropical medicine for the 21st century. *BMJ* 1995;311:860-2. (30 September.)

Genitourinary medicine should remain a separate speciality

EDITOR,—While we agree with the general thrust of Kevin M De Cock and colleagues' thesis—that tropical medicine should be subsumed within the speciality of infectious diseases—we do not agree with their assertion that "the uniquely British concept of a separate career structure for specialists in sexually transmitted diseases, divorced from the broader subject of infectious diseases, is ill adapted to a future within Europe and the broader world."¹ Britain—with 236 genitourinary medicine clinics countrywide, all run by appropriately trained physicians—now has one of the lowest prevalences of sexually transmitted diseases in western Europe (bettered only by Sweden).

The existence of this infrastructure has also enabled genitourinary medicine physicians to provide most of the care for people infected with HIV. Departments of genitourinary medicine are well placed to do this, with their policy of open access, strict code of confidentiality, and access to health promotion facilities. The training of genitourinary medicine physicians has been modified to take account of this new area of health provision, but we acknowledge that a broader experience of infectious diseases would be useful.

Many genitourinary medicine clinics now provide additional services for family planning, psychosexual counselling (including for erectile dysfunction), and colposcopy—that is, a complete sexual health service. Colleagues overseas, where genitourinary medicine is not a single speciality, envy the benefits of a single discipline; they do not urge us to join with others.

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Clinical care in resource poor countries is often provided by people outside the medical establishment

EDITOR,—We believe that the second topic in Kevin M De Cock and colleagues' analysis of the future role of tropical medicine in Northern countries—namely, the role and future of clinical services in resource poor countries—needs more debate.¹ The authors note that the World Bank's *World Development Report 1993* reaffirms the

importance of good clinical care.² They fail to emphasise that effective provision of the "essential clinical package" involves people outside medicine.

Firstly, in large areas of resource poor countries clinical care is provided by nurses and paramedical workers, who often work independently of physicians. Secondly, good clinical care includes nursing care and effective communication and counselling, especially for chronic diseases and conditions that require substantial behavioural change to prevent their recurrence. Skills to develop communities are also required if services are to have widespread impact. Training in these skills is rarely emphasised in Northern medical institutions. Thirdly, the development of clinical skills is wasted if resources and support systems are lacking or mismanaged. Management information systems are needed to monitor inputs, and surveillance systems are needed to monitor activities and diseases; these systems are usually not regarded as part of "tropical medicine." Fourthly, activities such as family planning and treatment of common childhood diseases, included in the "essential clinical services" package, could be (and often are) performed through channels outside the medical establishment.

Clinical services are, nevertheless, an important component of international health, and the development of a cadre of infectious disease specialists would benefit countries in the North and South alike. As De Cock and colleagues point out, experience in resource poor settings is valuable for clinicians specialising in infectious diseases in Europe; yet Northern institutions regard sending doctors to hospitals in tropical countries as part of overseas aid. Periods in developing countries may more appropriately be regarded as part of a person's training, which should contribute to accreditation but could be paid for in the same way that we expect those from resource poor countries to pay fees for training in the North.

Training in tropical medicine should reflect the changes in clinical priorities highlighted by De Cock and colleagues, emphasise management and communication skills, and give increased emphasis to training and supporting nurses and paramedics. Northern institutions and donors should work with colleagues from resource poor countries to determine how collaborative programmes, based in both the South and the North, can improve the global control of major diseases. Such programmes should recognise the extent to which the North benefits from the experience of the South.

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1 De Cock KM, Lucas SB, Mabey D, Parry E. Tropical medicine for the 21st century. *BMJ* 1995;311:860-2. (30 September.)

2 World Bank. *World development report 1993. Investing in health.* New York: Oxford University Press, 1993.

Videotaping of general practice consultations

EDITOR,—Jacqueline E Bain and Neil S D Mackay¹ suggest that the consent rate of 91% in our study of videotaped consultations in general practice² is evidence of coercion and state that consent rates of 4-10% are to be expected when coercion is removed. In neither paper that they quote in support of these figures were patients invited to be videotaped. In one study the authors asked patients to speculate how they might feel if so invited.³ In the other study patients were given leaflets inviting them to volunteer.⁴ Those patients who did not care one way or the other were included in the 90% who were claimed to have rejected videotaping. The suggestion that this

study produced a consent rate of 10% is not true: people cannot consent to something unless they have been asked. These points were made in 1987 in response to the original article.^{5,6}

We believe that many patients agree to videotaping out of a sense of altruism and an idea that they may be helping to train better doctors. Clearly, in some circles this could be seen as coercion. Bain and Mackay seem to consider it to be coercive merely to invite a patient to allow his or her consultation to be videoed. There has been a long history in Britain of patients agreeing to contribute to medical education at both undergraduate and postgraduate levels—for example, by being seen by medical students or acting as cases in examinations.

Since coercion in this context is impossible to define or measure we concentrated on outcome measures on the basis that it was important to determine whether videotaping had an adverse effect on the consultation. If 80% of our sample of patients did feel unhappy about the videotaping it is astonishing that the patients who were videoed reported the same satisfaction as those who were not videoed. Our patients did not produce an "acquiescence response set," as is shown by our results, and our statistics showed that it was extremely unlikely that we had missed a difference in satisfaction between the two groups.

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- 1 Bain JE, Mackay NSD. Videotaping of general practice consultations. *BMJ* 1995;311:952. (7 October.)
- 2 Campbell LM, Sullivan FM, Murray TS. Videotaping of general practice consultations: effect on patient satisfaction. *BMJ* 1995;311:236. (22 July.)
- 3 Bain JE, Mackay NSD. Patients' assessment of trainee general practitioners. *Med Educ* 1995;29:91-6.
- 4 Servant JB, Mathieson JAB. Video recording in general practice: the patients do mind. *J R Coll Gen Pract* 1986;36:555-6.
- 5 Boardman AP, Craig TKJ. Video recording in general practice. *J R Coll Gen Pract* 1987;37:180-1.
- 6 Mackay HAF. Video recording in general practice. *J R Coll Gen Pract* 1987;37:181.

Chemotherapy in non-small cell lung cancer

Large trial will reduce uncertainty

EDITOR,—The recent meta-analysis of the role of chemotherapy in non-small cell lung cancer suggests that treatments containing cisplatin improved survival.¹ The effect of chemotherapy seemed to be consistent across all subgroups (stage of disease, age, sex, performance status, and tumour histology). Because of the heterogeneity of the treatments used in the various trials, however, it was not possible to recommend a particular chemotherapy regimen or to be certain of the size of the benefit. Most importantly, it was not possible to state reliably whether a short course of a widely used cisplatin based treatment would improve survival, or by how much. The economic aspects and quality of life were also not addressed, for obvious reasons.

Considerable doubt therefore remains over the usefulness of combination chemotherapy in non-small cell lung cancer. To answer these questions we have designed a large randomised trial to compare chemotherapy with no chemotherapy in each of the four settings studied in the meta-analysis (surgery, surgery plus radiotherapy, radical radiotherapy, and supportive care). The recommended chemotherapy regimen is three