technique, and outcome of peripheral thrombolysis for the past two years.[2] This is a continual process to provide a system for the national audit of peripheral arterial thrombolysis, and so far over 450 events of thrombolysis have been recorded. In these, only 13% of infusions were given with a pulse spray technique, in a median time of six hours (range 1-78 hours).

Pulse spray lysis is certainly faster than conventional low dose techniques, but it requires expensive catheters and infusion systems. Other methods, such as high dose bolus thrombolysis and six hourly dose infusions, have also been reported to reduce infusion times without expensive equipment.[3,4] Personal communications with the manufacturers of pulse spray infusion catheters also suggest that relatively few hospitals in Britain use the pulse spray technique.

Little information is available on many of the techniques for peripheral thrombolysis, and low dose infusions remain the gold standard for many hospitals in Britain.

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1 Verstraete M. Thrombolytic treatment. *BMJ* 1995;311:582-3. (2 September.)
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Streptokinase is more economical than alteplase

EDITOR,—Marc Verstraete cites streptokinase and alteplase as alternative thrombolytic drugs for the management of myocardial infarction.[1] His guidance on choice is confined to the statement that use of streptokinase, aspirin, and heparin saves 26 lives per 1000 patients treated, whereas use of alteplase, aspirin, and heparin saves 35-37 lives per 1000 patients treated. The implication is that he recommends alteplase. He omits to mention that the cost of treating a single patient with alteplase (£750, all inclusive) is over nine times higher than that of using streptokinase (£81.50, including the cost of the diluent, transfer device, and infusion bag). An annual budget sufficient to treat 1000 patients with streptokinase could therefore save 26 lives whereas the same budget would allow only 108 patients to be treated with alteplase and could save only three lives.

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Timing is more important than choice of agent

EDITOR,—Marc Verstraete states incorrectly[1] that the accelerated tissue plasminogen activator regimen used in the global utilisation of streptokinase and tissue plasminogen activator for occluded coronary arteries (GUSTO) trial[2] "lowered the 30 day mortality to 6·3%, compared with 7·2% achieved with streptokinase, aspirin, and intravenous heparin." The 30 day mortality for the latter combination was found to be 7·4%. The figures quoted are for the combination of aspirin, streptokinase, and subcutaneous heparin in the same trial.

To quote this trial without mentioning the discussion that it has generated is misleading. By doing so Verstraete implies that streptokinase is good but that tissue plasminogen activator is better. This has by no means been proved to be the case. Many of the controversial issues surrounding the trial were summarised in a recent review.[3] The authors helped put the debate in perspective by emphasising that the timing of thrombolysis is much more important than the choice of thrombolytic agent.

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Are second opinions a right or a concession?

An important political issue

EDITOR,—Granting patients an unqualified right to a second opinion about their diagnosis or treatment would set in motion much needed cultural changes in medicine.[1] It would be a nail in the coffin of medical paternalism and of the "like it or lump it" health service. Giving patients the power to "vote with their feet" would flush out many poorly performing doctors.[2] It could generate sensitive new performance indicators—for example, for each individual consultant, the proportion of referrals that led to requests for a second opinion initiated by the patient and the proportion of these that resulted in changes of diagnosis or treatment.

We could soon expect the new arrangements to raise standards of diagnostic performance; promote both more considered choice of treatments and better monitoring of their outcomes; and reduce the frequency and scale of the costly, embarrassing, and tragic hospital blunders that have done so much in recent years to threaten patients' confidence that they are safe in the NHS's hands. This right would provide doctors with a powerful incentive to "accept that they could improve their practice and to work continuously to do so."[2] In conjunction with the lifting of restrictions on patients' rights of access to their medical records, the unqualified right to a second opinion could be a powerful deterrent to clinical fraud.[3]

So much good would obviously come of this right that we need to look carefully at any reasons adduced for not establishing it. The view that resources must be conserved seems to be an excuse rather than a reason, since the cost implications both of granting the right and of not granting it remain unknown. Before considerations of possible harm to patients could be seriously entertained there would need to be good evidence of its occurrence, nature, and gravity to offset the accumulating evidence that going without a diagnosis is harmful to patients, even if the ultimate diagnosis lacks clear implications for treatment.[4] If doctors are reluctant to countenance granting the right to a second opinion their reluctance needs to be acknowledged for what it is and the reasons for it examined openly and dispassionately.

Behind the smokescreen of contrived ethical debate and foregone economic conclusions lies a political issue. We can choose to acknowledge or ignore it. The core values embodied in medicine in the 21st century[5] may well hinge on the outcome of that choice.

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Case history breached confidentiality

EDITOR,—I take issue with two points raised in the debate over whether second opinions are a right or a concession.[1]

My first point relates to confidentiality in such an exercise. The doctors at Bethlem Royal and Maudsley Hospitals can easily be narrowed down to a shortlist of two or three, including me. If I am not one of those described then I have had an extraordinarily similar experience. I discussed the matter with a member of the *BMJ*'s staff soon after the article appeared, and he said that there is sometimes a dilemma between protecting confidentiality and the need for open debate. Has the *BMJ*, which has an excellent reputation for issuing professional directives, now lurched towards the tabloid genre?

Secondly, I take issue with Anthony J Pelosi's polemic against tertiary referral centres. Having done most of his training at the Bethlem Royal and Maudsley Hospitals, Pelosi knows that patients do not sit around there being overresearched. The patient discussed in the article would immediately have had a trial of clozapine. E B McGinnis is incorrect in saying that tertiary referrals are not free: all such referrals to my unit will be free until at least 1997. This is not an ethical debate but the all too familiar tale of a patient being denied a superior modern treatment because of the inertia, prejudice, and protectionism that bedevil the psychiatric profession. If the *BMJ*'s readers have any patients in whom clozapine should be tried, I and my colleagues, Dr Reveley and Professor Murray, will be happy to accept appropriate referrals. The patients will certainly not sit around for months having "expensive brain scans and well meaning attempts at psychological treatment"—our waiting list is far too long for that.

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1 Pelosi AJ, McGinnis EB, Elliott C, Douglas A. Second opinions: a right or a concession? *BMJ* 1995;311:670-2. (9 September.)

New developments have transformed outlook for patients with schizophrenia

EDITOR,—In the debate on whether patients with schizophrenia should have the right to referral for a second opinion against the wishes of their local psychiatrist, Anthony J Pelosi attacks one of my lecturers (Dr B) for "bizarre behaviour" in advising a relative that my colleagues and I are willing to see patients in such circumstances.[1] While we much prefer to cooperate with local doctors, our experience has been that a small number of psychiatrists use ineffective or counterproductive treatments and yet oppose a referral. In such a situation where the patient continues unnecessarily to have hallucinations or crippling side effects of inappropriate drugs, his or her