

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 experience, 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 pro-

vision 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.