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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Management of patients after myocardial infarction

SIR,—Professor J R A Mitchell's analysis of the timolol study[1] (16 May, p 1565) invites comment on an aspect of such trials which he did not specifically allude to—namely, the extent to which such largescale studies have influenced or may in future influence clinical practice. When a treatment is clearly effective news of it readily permeates from its point of origin through the medical profession and soon colours action at the periphery. Practice thus moves quickly in the direction pointed by the new research, and statistics are hardly relevant. But in a field where many hundreds or even thousands of patients require study to show a significant result we may well find that research and practice drift apart. A succession of papers on aspirin, dipyridamole, sulphinpyrazone, beta-blockers, and anticoagulants again have now fallen with a loud plop into the pool of medical awareness, each sending out greater or smaller ripples. But what has happened thereafter? Do the authors, or the profession as a whole, ever discover what the practical effect of these labours is? Do large numbers of clinicians, or only a scattered few, put the suggested therapy into practice? What indeed do the trial participants themselves do?

Because of our reluctance to see the stream of medical progress glide by without us, and our concern to omit no reasonable treatment that might benefit our patients, we are as a profession often absurdly gullible. But against this gullibility is set another trait of human nature, a mixture of inertia, scepticism, and conservatism. There are indeed good reasons for caution in therapy, as thalidomide, practolol, and perhaps clofibrate have taught us. The more experienced a physician the more this factor may weigh. The statisticians point out that a small benefit widely diffused will improve the health or save the lives of thousands. But what they overlook is the state of mind of the prescriber when confronting his patient: for he will never *know* whether, if he gives treatment, he has influenced the future of his *individual* patient one jot or tittle. (A very brief but telling annotation by Dr G E Burch appeared in 1975[2] and ran as follows: "Do we really know when an infarct is prevented? We do know when it is produced.") A 1 in 10 or 1 in 5 chance of influencing events may not tip our physician into action, especially if he has a reluctant patient, knows the problems of compliance, or has come across unpleasant side effects. It is quite a different matter from prescribing digoxin for atrial fibrillation, or diuretics for oedema, or antibiotics for endocarditis. Even prescribing for hypertension is not comparable, for here the