pulmonary resuscitation performed. I am sure that Rawlinson, a staff doctor in accident and emergency, gives such resuscitation every day. I cannot remember when I last did. I attend an updating course every two years at our local postgraduate centre, but I have not needed to use advanced cardiopulmonary resuscitation, and the skills that are needed are soon lost.

Thirdly, Rawlinson seems to imply that a general practitioner should be available 24 hours a day for care and counselling about adverse life events. While I accept that a sudden death is different (and I would always offer to visit a bereaved patient as soon as I knew of the bereavement—the deputising services always inform us promptly, but hospitals are rarely so efficient), patients are increasingly "medicalising" adverse events and seem to expect general practitioners to have a means of putting life right for them. I am fed up with being asked to soothe people in tears because their husband has left, they have had a minor car accident, their handbag has been stolen, or their cat has died. The problem is that people seem to have no one else to turn to: there is no real "care in the community," just general practitioners trying to do their best with minimal back up.

Has Rawlinson ever done any general practice?

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1 Rawlinson JN. Deputising general practitioners' role in emergencies. *BMJ* 1995;311:394. (5 August.)

Journals sponsored by single companies

EDITOR,—Martyn Partridge suggests that sponsorship of journals by pharmaceutical companies should be obvious and stated boldly rather than have to be deduced.[1] The code of practice for the pharmaceutical industry of the Association of the British Pharmaceutical Industry, which is operated separately from the association by the Prescription Medicines Code of Practice Authority, was recently amended with this point in mind. It now states, "All material relating to medicines and their uses which is sponsored by a pharmaceutical company must clearly indicate that it has been sponsored by that company." Anyone who considers that this requirement has not been met in respect of any particular item can complain to the authority about it.

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1 Partridge M. Journals sponsored by single companies. *BMJ* 1995;311:394. (5 August.)

Videotaping of general practice consultations

EDITOR,—L Malcolm Campbell and colleagues state that the consent rate for videotaped consultations in their study was 91%, which shows the vulnerability of patients to coercion.[1] The method of obtaining consent has an important bearing on this figure and is not described by the authors. When coercion and bias are removed, consent rates in the order of 4-10% are to be expected.[2,3] Last year the General Medical Council issued guidelines on videotaping consultations to offer patients some protection from exploitation, and Campbell *et al* have noted that adherence to a similar protocol has resulted in falling consent rates.[4]

We also take issue with the authors' unquestioning acceptance of the results of their questionnaire survey on patients' satisfaction. The subjects' responses are likely to have been influenced by a perception that their doctor's participation in a videotaped consultation renders this an acceptable or desirable exercise, particularly in practices in which consultations are habitually videotaped. In addition, there is the phenomenon of patients who agree with every statement, which was recognised by the designer of the questionnaire used in the study, who warned of the confounding effect of "the acquiescence response set."[5]

Furthermore, in these days of widespread ownership of and exposure to camcorders it is fatuous to argue that patients who have not previously been asked to take part in a videotaped consultation cannot give a valid opinion about their expected response to such an event. While most of us have never broken a limb, this does not stop us giving an authoritative statement on whether we would expect this to have a beneficial or detrimental effect on our quality of life.

Campbell and colleagues have failed to address inherent biases that have corrupted other, similar studies. Their results are therefore misleading and do not refute our evidence that patients are vulnerable to coercion into participation in videotaped consultations in which they expect to feel uncomfortable or inhibited.

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1 Campbell LM, Sullivan F, Murray TS. Videotaping of general practice consultations: effect on patient satisfaction. *BMJ* 1995;311:236. (22 July.)
2 Servant JB, Mathieson JAB. Video recording in general practice: the patients do mind. *J R Coll Gen Pract* 1986;36:555-6.
3 Bain JE, Mackay NSD. Patients' assessment of trainee general practitioners. *Med Educ* 1995;29:91-6.
4 Campbell LM, Howie JGR, Murray TS. Use of videotaped consultations in summative assessment of trainees in general practice. *Br J Gen Pract* 1995;45:137-41.
5 Baker R. Development of a questionnaire to assess patient satisfaction with consultation in general practice. *Br J Gen Pract* 1990;40:487-90.

Measurement of bone density in osteoporosis

EDITOR,—It is difficult to imagine a more wrong headed approach to osteoporosis than that proposed by E M Tayler.[1] The first major misconception is that a bone density scan rarely influences a decision to start or continue hormone replacement therapy. In many patients this is now the main reason for starting, and often the most important for continuing, such treatment, if necessary life long, to prevent further bone loss. There is currently no more accurate technique of measuring a postmenopausal adverse factor than dual energy *x* ray absorptiometry. This also emphasises the importance of early screening: I would recommend screening at the age of 40, when peak bone mass is still present, so that advice on lifestyle can be emphasised when osteoporosis is still preventable. Repeat screening at the menopause would then indicate the importance of starting hormone replacement therapy then. Only then will we be able to assess the long term impact on rate of fracture, which, with preservation of peak bone mass, is likely to be considerable.

The indications that Tayler lists for measurement of bone density in Oxfordshire will ensure that no impact on the problem is made there. Throughout the letter Tayler says that such measurement would be worth while only if it would greatly influence the woman's decision, but that decision cannot be made until one knows the state of the skeleton. Nobody would disagree with Tayler's comments about patients taking prednisolone, but the first line of treatment in high risk patients with established osteoporosis is hormone replacement therapy rather than biphosphonates. Tayler's comment on radiological suspicion of osteopenia is out of date as an *x* ray film will not show appreciable bone loss until 30-40% has been lost.

Tayler admits that osteoporosis is a major public health issue, but, clearly, no proper guidance about its alleviation will be given by the public health medicine department in Oxfordshire and patients will have to look elsewhere for help.[2]

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2 Andersson SI, Mortimer CH, Perry W. Bone density screening for osteoporosis. *Lancet* 1990;336:502-3.

New deal shifts may increase house officers' stress

EDITOR,—The new deal was implemented to improve the working conditions of junior doctors by reducing the total hours worked and, where the intensity of work was high, by changing the pattern of working from a traditional on call rota to full or partial shifts.[1] No research has been carried out, however, to assess whether the change from an on call rota to full or partial shifts in high intensity jobs has achieved the beneficial effect initially predicted.

Two postal surveys of junior doctors were conducted in the west midlands, the first on all preregistration house officers trained in Britain who were working in the region and the second on a random sample of senior house officers working in the region. Both surveys used the occupational stress indicator to determine total job satisfaction and mental ill health (cognitive aspects of strain) and physical ill health (somatic symptoms of anxiety and depression). Details of the system of work (on call rota and partial or full shift) were sought. The survey of preregistration house officers had a response rate of 83·4% (196/235) and that of senior house officers a response rate of 57·8% (292/505).

Senior house officers had significantly higher levels of physical ill health (32·30 (SD 9·14); a high score indicates poor health) than a large group (n=6326) of non-health care workers[2] (29·60 (9·79), $P<0·001$) and a small group (n=40) of junior doctors at all grades (28·35 (8·29), $P<0·01$).[3] Additionally, they had significantly lower levels of job satisfaction (79·47 (17·56); a high score indicates low job satisfaction) than non-health care workers (81·76 (16·64), $P<0·05$). Preregistration house officers had significantly lower levels of job satisfaction (71·86 (12·99)) and significantly higher levels of mental ill health (61·50 (14·31)) and physical ill health (33·87 (10·97)) than non-health care workers (81·76 (16·64), $P<0·01$; 56·54 (12·25), $P<0·01$; and 29·69 (9·79), $P<0·01$, respectively) and junior doctors (83·22 (11·22), $P<0·01$; 55·30 (12·25), $P<0·05$; and 28·35 (8·29), $P<0·01$, respectively). A one way analysis of variance was performed to determine differences in the mean scores for job satisfaction and mental and physical ill health of those working the three different systems of work. Tukey's procedure was used to determine which means differed significantly from each other (reported to be significant at the 5% level of probability; table).

Our work suggests that a partial shift system may lead to better job satisfaction than an on call rota for senior house officers but to decreased job satisfaction and increased physical ill health for preregistration house officers. A possible explanation for this is that partial shifts are more isolating for the individual doctor than an on call