Sir,

Recruiting properly qualified practice counsellors is no easy task. The problem, and one possible solution, was accurately described by C V Newman of the British Psychological Society (September Journal, p.388). As general practitioners and psychiatrists working in a university health service we would encourage readers to use a larger net with smaller holes when trawling for staff and to sort carefully through the resulting catch. Chartered counselling psychologists are not the only fish in the sea; scientific psychology is not the only way to a sympathetic understanding of human nature. The psychological and emotional problems seen in our practice differ markedly from those managed by psychologists working in specialist hospital and community based psychiatric services.

Medical staff at the London School of Economics work closely and cooperatively with competent and effective lay counsellors and psychotherapists. In recent years none have been members of the British Psychological Society. Several had undergraduate degrees in the arts, humanities and social sciences while others were experienced teachers, nurses and social workers. All had trained with reputable psychodynamically oriented organizations affiliated to the 'Rugby conference' at the British Association for Counselling, which has a division which looks at counselling in medical settings. The affiliated organizations include the Guild of Psychotherapists, the British Association of Psychotherapists, the Institute of Psychoanalysis and the Westminster Pastoral Foundation.

There is not yet a broadly based statutory body which registers and regulates the psychotherapists and counsellors that we choose to employ. The 'Rugby conference' is too broad a coalition of the mainline and the esoteric while the British Psychological Society sounds too restrictive.

Perhaps the prospect of National Health Service employment and family practitioner committee scrutiny will encourage the psychotherapy and counselling professions to organize themselves along the lines suggested by Holmes and Lindley.1 Well informed general practitioners, as prospective employers, are in a good position to use selection pressure to help this process along. Until then the following criteria may be useful. Prospective counsellors must:

1. Be mature, educated and 'orthodox' enough to be respected by their clients and colleagues.
2. Have satisfactorily completed at least two years training with an organization affiliated to the 'Rugby conference'; this should include theory, personal therapy and supervised practice.
3. Be aware of their own limitations and of the value of medical treatment of psychiatric disorder.
4. Be able to recognize borderline, psychotic and suicidal patients.
5. Work to a code of ethics, have regular supervision and carry their own indemnity insurance.

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Reference

Complementary and allopathic cooperation

Sir,

The interesting and timely paper by Budd and colleagues concerning cooperation between complementary and allopathic medicine (September Journal, p.376) suggested a need for debate about the formal acceptance of some complementary disciplines and that such discussions would need to include the views of alternative practitioners' organizations. Perhaps, in my dual role of orthodox scientist and scientific officer of the Osteopathic Association of Great Britain, I can offer some comment on the subject.

There would seem to be two fundamental issues which need to be clarified before considering the integration of a complementary discipline with general practice. First, does the complementary discipline consider itself to be offering a therapy or an alternative system of 'medicine'? Secondly, is the approach of the complementary discipline effective and does it offer something which allopathic management does not?

If a complementary discipline feels it is providing an alternative system, which by definition renders competing systems potentially redundant, it is difficult to see how the orthodox and heterodox can peacefully coexist. However, if the complementary discipline believes it is offering a novel method of treatment (albeit based on peculiar diagnostic and assessment abilities) then open dialogue and assessment of efficacy is facilitated. As far as osteopathy is concerned it has been argued that what is being provided is a therapy which does not require invocation of alternative systems to explain its claimed efficacy.1 Thus, for this profession at least, there is the possibility of following a conventional scientific route to explore its value for specific and recognizable conditions. The need for research in this field has been stressed by a government committee2 as well as in statements by orthodox3 and heterodox4 practitioners alike.

Accepting that such research is required, the question then arises as to where it should be conducted. One possibility is that of hospital outpatient departments which arguably are a site of research expertise. However, it has been shown that patient populations in hospital departments and office practices are significantly dissimilar in a number of important respects.5 Since complementary therapies are practised in office-based environments, drawing on the general population, it would seem appropriate that investigative studies of their efficacy should be performed within general medical practice. Indeed one of the problems that has faced researchers in this field has been the lack of a suitable clinical population and study location. In this respect the paper by Budd and colleagues is particularly relevant as they have shown that the orthodox and heterodox can coexist clinically without apparent problems, and that the range of conditions treated (at least by the osteopath) closely resembled that found in private practice.

That large numbers of patients seek complementary health care is not in doubt, nor is the fact that financial constraints prevent many others from obtaining these forms of care. To move dramatically to wholesale provision of complementary therapy within orthodox primary care would be inadvisable (even if it were practicable), but the paper by Budd and colleagues can be seen to have removed one of the major impediments to essential clinical trials of complementary medicine. Furthermore, now that there are orthodox and heterodox practitioners fully prepared to cooperate, it is to be hoped that funds can be made available for extensive clinical research.

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References

Grooming for general practice

Sir,
Dr Styles defined many of my own misgivings about general practice training in his excellent William Pickles lecture 1990 (July Journal, p.270) and I agree with his proposed modifications to medical education.

I would, however, like to suggest a small alteration in terminology which I find helps me overcome a large psychological barrier to the overall aims of training for general practice and that is to the word 'training' itself. This finite term, meaning 'teaching a specified skill' implies that, once learnt, there is nothing more to learn. I prefer the word 'grooming', defined in the Oxford dictionary as 'preparing or training (a person) for a particular purpose or activity (was groomed for the top job)', as it enables me to broaden my attitude to teaching the trainee.

Nevertheless, I realize that we cannot rename trainers grooms, in case the trainees feel that they are being treated like horses.

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Research for all in general practice

Sir,
Your editorial (September Journal, p.357) does not do justice to its title. If 'Research for all' is to mean what it says, research must become a routine activity for every practice. How can we plan our work to achieve future objectives if we do not know where we are starting from? Despite all its serious errors, the new contract does at least oblige us to set targets and measure their attainment, and this involves systematic, standardized recording of clinical events, related to an enumerated base population. The contract can and must be revised to bring it in line with the experience of those of us who have been doing work of this kind for 20 years or more, none of whom appear to have been consulted; but the positive features of the contract will remain, and will surely be extended to wider and more clinically interesting fields.

Spurred by the requirements of the contract, over half of all practices are already using computers to record clinical data, and within the next two years the remainder will probably join them. Competing computer systems will fall in number, and converge in format. Exasperation with futile processes undertaken merely because they are paid for will spur us to produce the evidence we need for a contract which measures outcomes, regardless of how they are attained. Many intermediate outcome measures are already available: blood pressure in hypertensive patients, glycosylated haemoglobin levels in diabetics, body mass index in the obese, number of fits in epileptics, hospital admissions in asthmatic children, and so on. The minister of health should be interested in ends and not in means. He should want to know the proportion of a population whose blood pressure, body mass index, peak expiratory flow rates and tobacco and alcohol intake had been recorded, not whether clinics are held which claim to be able to change these indices.

Training in sophisticated research methods, and a career structure for academic general practice, are real and important problems, worsened by the philistine times in which we live. They must be addressed and the Royal College of General Practitioners should help university departments to solve them, but that is not the most important task. Research is a systematic search for relevant truth, and testing of truth by active search for error; no more, no less. Without research of some kind, no practice can get itself beyond passive response to patient demand. Research in these simple terms is not an intellectual luxury, an option for enthusiasts, but a necessity for everyone in socially responsible practice.

All general practitioners are now undertaking research in their own practices; sharpening up the definition and age structure of their populations at risk, looking at population related rates for some clinical activities, and publishing what they find in an annual report. We ought to be helping them, not just in practical ways, but by assisting the birth of a new kind of clinical and social imagination, which no longer regards research as a minority option. Our great opportunity is not the recruitment of a few more professionals, but the accession of 30 000 absolute beginners.

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Sir,
Your editorial clearly described the difficulties experienced in performing research work in general practice, particularly now that the bureaucracy of practice is diverting attention from clinical work.

Mention was made of the Syntex awards and the research units, and of James Mackenzie, but of no others. You ask why research is not yet an integral part of the culture of general practice, and I think the answer must be that the mind of a researcher is rare anywhere. You should also realize that it takes many years for a general practitioner to obtain 'respectability'. For example, I was one of the first to observe tremor reduction by beta blockade,1 but my publication caused little stir initially because I was only a general practitioner.

Whereas James Mackenzie's research and that of William Pickles were limited to specifics, John Fry's studies have covered a remarkable range of common diseases, and have affected patient management more widely than any other research I can think of. Having met Pickles, and seen Fry's method, I must conclude that research depends upon an unusual combination of mental properties: tenacious curiosity, the ability to identify events requiring examination, wide and critical reading of the work of others, and the construction of a methodology for recording and analysing data. Some of these properties can be taught, but the devotion of time and effort outside the already demanding hours of consultation and administration require unusual energy, restriction of other interests, monastic seclusion, a legalistic balance of judgement concerning the results and literary skills in producing a paper.

It seems to me that one of the main areas for which general practitioners are perhaps uniquely suited is the longitudinal study of the ageing process. My own work2 has shown that changes in the internal environment, which lead to the diseases of ageing, and which lie on a scale between apparent normality at one end and gross disturbance at the other are fundamental to our understanding of atherosclerosis, age-related obesity, essential hypertension, type II diabetes, cancer, and so on. We no longer live in a time when one has to decide whether one has a disease or not; instead, diseases are to be expected in later life when what matters is not so much their presence but the rate at which they progress.

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