Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

General practice and the new science emerging from the theories of 'chaos' and complexity

Sir,

I hope that the discussion paper by Griffiths and Byrne (October *Journal*)[1] on complexity and general practice does indeed create a lot of discussion. They raise questions of great importance for the generalist role. They remind us that the generalist arena is not a laboratory where simple causes result in simple effects, but a 'real world' where multiple, potentially conflicting factors interact. The authors offer a model of how this complexity can be understood. However, I think that they are inappropriately leading us to believe that complexity theory can lead to control by 'identify(ing) what factors were important in bringing about change'.

Ralph Stacey, in his book *Complexity and Creativity in Organisations*,[2] introduces the metaphor of a complex situation as a 'self-organising learning system'. This seems to me to be very helpful because it reminds us that what is going on in the midst of complexity is individual and group learning, and it is this that allows all of the various components to grow. This growth happens in a way that makes sense to those involved as they develop their sense of identity and culture. This idea that a complex system can organize itself is radically different from the idea that various component parts compete or add to each other in a linear 'survival of the fittest' way. It calls into question the ability of tests such as cluster analysis and loglinear analysis to make sense of what is going on, and asks for a focus on the processes that allow people to meaningfully interact and learn from each other.

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References

1. Griffiths F, Burn D. General practice and the new science emerging from the theories of 'chaos' and complexity. *Br J Gen Pract* 1998; **48:** 1697-1699.
2. Stacey RD. *Complexity and Creativity in Organisations.* San Francisco, CA, USA: Berrett-Coehler, 1996.

GPs' continuing medical education

Sir,

Dr Smith and his colleagues (October *Journal*)[1] are to be congratulated on their review article of GPs' continuing medical education, describing extensive educational activity and expertise.

Their call for the resolution of the tension between educational 'wants' and 'needs' is timely if we are to move from the present fragmented system, with its soft focus on patient care, to a fully professional, resourced, and validated activity targeted on patient care and its outcome.

Integration of education with audit, research, and clinical effectiveness becomes ever more necessary. Clinical governance can be the vehicle for this, if a developmental approach is adopted to maintaining and enhancing clinical standards.

Since acceptance of Smith's review, Elwyn has advocated professional and practice development plans, involving all of the primary health care team.[2] An undertaking of this nature is to be welcomed if focussed on patient care problems identified by audit. Resources and expertise will be vital for success.

While describing Kolb's theory of Experiential Learning, the review article does not progress to describe Kolb's learning styles — an individual's characteristic method of receiving and using information in learning.[3] To date, there has been only one limited study of UK GPs' learning style, using Honey and Mumford's Learning Style Questionnaire, which commented on the potential for mismatch between learning and teaching styles.[4]

The challenge for us now is to define, deliver, and evaluate problem-solving education. A scientific, organized approach to this will bring benefits for patients. The skill will be the ability to tailor this approach to individual GPs' styles, retaining the art of general practice with its intuition, creativity, and empathy.

Can we invest in exchanging our scattergun for a bespoke target rifle?

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References

1. Smith F, Singleton A, Hilton S. General practitioners' continuing education: a review of policies, strategies, and effectiveness, and their implications for the future. *Br J Gen Pract* 1998; **48:** 1689-1695.
2. Elwyn GJ. Professional and practice development plans for primary care teams. *BMJ* 1998; **316:** 1619-1620.
3. Kolb D. *Experiential learning: experience as the source of learning and development.* London: Prentice-Hall inc., 1984.
4. Lewis A, Bolden K. GPs and their learning styles. *J R Coll Gen Pract* 1989; **39:** 187-189.

North West Region Research Practice Initiative: a general practitioner's perspective

Sir,

In 1995, as part of a General Practice Research Initiative, funding was made available for five North West Region Research Practices. The scheme aimed to introduce research activities to practices with very little previous research experience. It was envisaged that the researchers would develop research skills relevant to their project in an evolutionary fashion, assisted by their mentors or supervisors with the backup of a project coordinator and regional research and development resources. This initiative contrasts with

previous models of research general practices in which the lead GPs had research experience.[1]

In 1996, a general practice in Wigan was designated as one of the five research practices in the North West of England. The practice had little previous research experience, few research-oriented resources, and had a solo researcher: a GP. Practical difficulties encountered included:

- initial cash flow problems,
- problems finding locum to cover to release the GP for research time,
- lack of basic research skills,
- lack of knowledge about resources available and how to access them,
- time constraints resulting from inefficient use of limited protected time,
- encroachment of practice affairs on protected time,
- a feeling of isolation and lack of communication between the steering committee, supervisor, and GP.

These difficulties were overcome by accessing new resources and by developing a number of new skills. New resources included:

- finance to enable the practitioner to have protected time,
- a supervisor/mentor for advice,
- help with information technology, and
- a university library.

Skills developed included:

- time management,
- negotiation and liaison,
- learning basic research skills such as writing research proposals, applying for ethical approval, basic methodology, statistics, and information technology.

This initiative, involving practices with little experience, few resources, and no initial formal training, did result in the production of good quality research from the 'coal face' of general practice, resulting in a number of conference presentations and research papers on the subject of women's menopausal health care. However, using this model of research practices has a number of limitations and appears to be a very inefficient way of funding general practice research. This type of initiative might be made more effective by ensuring resources and training are more readily available at an early stage, and perhaps by means of linking with more experienced practices in a research network.[2]

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References

1. Smith LFP. Research general practices: what, who, and why? *Br J Gen Pract* 1997; **47:** 83-86.
2. Smith LFP, Carter YH, Cox J. Accrediting research practices. *Br J Gen Pract* 1998; **48:** 1464-1465.

Applying the results of RCTs

Sir,

In their comments concerning my paper on applying the results of randomized controlled trials (RCTs),[1] Kieran Sweeney *et al* (September *Journal*) take me to task over ignoring the qualitative aspects of the diagnostic and therapeutic process in the consultation. This was not the point of the paper. I used the example of acute sinusitis to illustrate how external evidence from RCTs can be used to estimate the likely risks and benefits of antibiotic treatment, discussing the limitations and assumptions of this approach in the process.

Others have written eloquently about how external evidence from RCTs can be incorporated into the qualitative aspects of each patients' concerns and expectations during the process of a consultation.[2,3] Surely, all GPs recognize that both approaches (qualitative and quantitative) are necessary and complementary. Continuing to view either aspect as exclusive to the other perpetuates a divide that, to my mind, does not and should not exist.

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References

1. Fahey T. Applying the results of clinical trials to patients in general practice: perceived problems, strengths, assumptions, and challenges for the future. *Br J Gen Pract* 1998; **48:** 1173-1178.
2. Greenhalgh T. Is my practice evidence-based? *BMJ* 1996; **313:** 957-958.
3. Sullivan F, MacNaughton R. Evidence in consultations: interpreted and individualised. *Lancet* 1996; **348:** 941-943.

Triage of same day consultations

Sir,

Gallow (July *Journal*)[1] is right to suggest caution in generalizing from our pilot study of a single nurse providing telephone triage of same day consultations in the mornings in 1995.[2] However, our latest research, with four triage nurses working throughout the day, confirms our original findings. Between 4th March 1998 and 3rd June, 1998, there were 3071 urgent consultation requests for our practice of 11 300 patients. After excluding poor information capture (126) and DNA's (103), 2842 patients formed the basis of this second study. Forty seven per cent (1328) were managed on the phone by the nurse, 19 per cent (535) saw the nurse in the surgery, and 32 per cent (906) saw the doctor. This contrasts with 26 per cent for telephone advice, 22 per cent seeing the nurse in the surgery, and 45 per cent seeing the doctor in the autumn of 1995.[2]

Another criticism of our pilot study by Pitts (June *Journal*)[3] was that a large proportion of patients seeing the nurse received a prescription. We have no prescribing data for nurse consultations in the surgery, but, for those that only had telephone advice, the percentage of patients receiving a prescription fell from 21 per cent in 1995 to four per cent in 1998. These new figures show that an increasing proportion of requests to see the doctor are managed on the phone, but without an increase in telephone prescribing.

Both Pitts and Gallow are concerned about triage pandering to patients' wants and discouraging self-care. At the inception of our service there was a tendency to give patients what they wanted and to avoid confrontation.[4] We are now more active in giving advice and promoting self-care. This is good for patients and essential for the practice: unrestrained demand could cripple what is a very effective service.

Finally, triage — even out of hours — is in its infancy in general practice in the UK. It will become more popular and continue to change. We are advocates of telephone triage, but recognize that there are many unanswered questions about the use and value of this form of working. These cannot be answered by enthusiasm or rhetoric, but only by critical thinking and research that includes patients and professionals.

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References

1. Gallow R. Practice nurse triage. *Br J Gen Pract* 1998; **48:** 1436.
2. Gallagher M, Huddart T, Henderson B. Telephone triage of acute illness by a practice nurse in general practice: outcomes of care. *Br J Gen Pract* 1998; **48:** 1141-1145.
3. Pitts J. Practice nurse telephone triage. *Br J Gen Pract* 1998; **48:** 1344.
4. Gallagher M, Johnson C, Huddart T, *et al*. *'The nurse will take your call': the development and evaluation of practice nurse triage in acute disease management in a general practice*. South Shields: Central Surgery, 1998.

Recruitment for drug trials

Sir,

Dr Armstrong writes to discuss Glaxo Wellcome's studies of Lamictal™ (lamotrigine) in bipolar disorder (September *Journal*).[1] She addresses two specific points regarding advertising for recruitment and use of placebo in clinical trials of Lamictal in bipolar depression.

Glaxo Wellcome, together with the independent experts in bipolar disorder who contributed to the trial design, make the safety of patients our top priority in investigating much needed alternative therapies for bipolar disorder.

To adequately evaluate new therapies, studies must recruit sufficient patients to answer the question of both absolute and relative efficacy and safety. Advertising for patients is a widely accepted and highly regulated method of enhancing recruitment and requires Ethics Committee approval in advance. Once identified, patients undergo rigorous telephone screening to assess suitability before attending the study site.

At the study site, all patients give full and informed consent before entering the screening process. This includes a full explanation of the trial design and objectives, allowing ample opportunity for questions. Time is also allowed for a patient to consult with their current psychiatrist, GP, family and friends. It is made clear to patients that they may withdraw at any time without prejudice to their treatment. Prior to full entry into the study, information from a patient's current psychiatrist is sought and the patients are adequately protected within the trial process irrespective of how they are initially recruited.

The use of placebo is not only a regulatory requirement for evaluation of new therapies, but also gives the benefit of smaller studies run over a shorter duration. This means that fewer patients are exposed to an unproven intervention and allows an answer on efficacy more quickly. If that answer is positive, patients should be able to benefit early. If it is negative, fewer patients will be exposed to an ineffective therapy.

With regard to the design of this particular trial and the use of placebo, the stabilization of the patient's mental state must be considered. Patients enter part one of the study during an uncontrolled mood episode and adjunctive Lamictal is given until the mood episode is resolved. Lithium is withdrawn over a period of not less than three weeks, according to accepted guidelines.[2] Therefore, patients who enter part two are stabilized, while those not responding to medication remain on lithium and do not enter the second part of the trial.

In part two, the blinded randomized phase, patients receive one of five treatment options: lithium, one of three different doses of Lamictal, or placebo. The trial is double-blinded so neither the investigator nor the patient knows if the patient is on placebo. However, patients are monitored regularly and, if they show mood relapse or recurrence, the investigator may either withdraw them from the trial without prejudice and prescribe further medication, or keep them in the trial and prescribe add-on therapy.

Glaxo Wellcome vigorously adheres to the principals of good clinical practice as part of our standard operating procedures in all our research programmes, and hopes that this particular trial will lead to progress being made in the management of this difficult-to-treat disorder.

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References

1. Armstrong E. Recruitment methods for drug trials. [Letter.] *Br J Gen Pract* 1998; **48:** 1615.
2. Baldessarini RJ, Tondo L, Floris G, Rudas N. Reduced morbidity after gradual discontinuation of lithium treatment for bipolar I and II disorders: a replication study. *Am J Psychiatry* 1997; **154:** 551-553.

Use of alternative treatments by patients with psoriasis

Sir,

Psoriasis is a chronic dermatosis that affects up to 2% of the UK population. Conventional treatments, at best, 'clear' the condition temporarily, and many patients experience significant distress and social disability that results in a constant demand for treatment.[1] Alternative treatments are widely available and are generally perceived by patients as being harmless.[2] We examined the use of alternative medicines in a sample of patients attending a specialist psoriasis clinic in the UK.

Fifty patients were recruited from the psoriasis clinic at Hope Hospital, Salford, and were interviewed by a researcher (RM) using a structured questionnaire. There were 23 female and 27 male patients, aged 13 to 72 years. The majority had chronic plaque psoriasis of several years' duration. Thirty-four (69%) patients had tried 81 alternative treatments (mean treatments per patient = 2.4), of which 23 were considered successful. Table 1 lists the treatments and reported effects. Several patients had experienced side-effects attributable to the alternative treatment, including vomiting and diarrhoea (Chinese remedy and a 'natural' product). The most common reason for trying an alternative was dissatisfaction with the results of conventional treatment (18), although 12 patients cited 'recommendation' as their main reason. The most common sources of information were mass media (21), friends and relatives (27), and own 'experience' (13). Ten recommendations were from other psoriasis patients and three were from health care professionals.

Twenty-six per cent of the alternative treatments (21) involved the use of sunlight and non-prescription tanning equipment. The remainder embraced a wider range of alternative treatments than those reported in other studies. This, presumably, reflects the availability of products and information in the UK rather than exceptional behaviour by these patients.

The median estimated expenditure on alternative treatment was £101–500 per patient, although six patients had spent £1000. This observed 'willingness to pay' for alternative treatments supports Finlay's finding that 38% of patients would pay up to £10 000 for a complete cure of their psoriasis.[1]

This preliminary study has shown that patients with psoriasis use a wide range of alternative therapies and that they appear to place a high value on treatments that offer the possibility of clearing psoriasis. Physicians caring for patients with psoriasis need to be aware of this facet of patient behaviour and to incorporate questions about the use of alternative medicines into their routine practice.

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Table 1. Alternative treatments used by patients with psoriasis and reported effects.

Type of treatment	Number of patients using treatment (n = 34)	Effect of treatment: Effective	Partially effective	Not effective	Made worse	N/A
Acupuncture and acupressure	4			4		
Aromatherapy	2		1	1		
Chinese herbal	6	2		4		
Herbal	6		1	5		
Homeopathy	5			3		2
Hypnotherapy	2			2		
Dead sea therapies	6	1		4	1	
Sunlight (natural or artificial)	21	13	3	4		1
Dier (exclusion diets or supplements)	14	5	2	7		
OTC topical treatments	7	1	2	4		
Other	8	1		7		
Total	81[a]	23	9	45	1	3

[a]Some patients used more than one treatment.

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References

1. Finlay AY, Coles EC. The effect of severe psoriasis on the quality of life of 369 patients. *Br J Dermatol* 1995; **132:** 236-244.
2. Eisenberg MD. Alternative therapies for cutaneous disorders. *Cutis* 1997; **133:** 379-380.

Oral contraception and health: what do GPs monitor?

Sir,

Following the editorial by Vessey and the articles by Hannaford and Kay (October *Journal*),[1,2] which address the morbidity and mortality associated with the oral contraceptive pill, I would like to know their opinion on the frequency and content of checks on oral contraceptive users. To determine the opinion of other GPs and fulfil some of the Bolan criteria that we should maintain a standard at least as good as our colleagues, a survey of 103 GPs was carried out in southern England.

Questionnaires were given out to all participants at four different educational events: a refresher course (34), a teaching methods course (28, 1 no reply), and a family planning course (13, 4 no reply), giving a response rate of 95%. Ages ranged from 29 years to 64 years, with a mean of 42 years. No doctor replied twice. Data was analysed using SPSS (Table 1). There was no difference detected between the courses. The proportions checking blood pressure (97%) and weight (64%) were similar to a cohort studied by Owen-Smith, which included clinicians with a special interest in family planning carrying out pre-prescription checks.[3] The proportion of GPs stating that they would do vaginal (61%) or breast (47%) examinations in general practice was more than double that for doctors specializing in family planning. Vaginal examination rates may be reported as higher because of the requirements to do three-yearly smear tests.

Outside this context, is it ethical to do an internal or breast examination when they are of uncertain benefit and are not deemed necessary by many doctors in this study and in the study by Owen-Smith? An examination also takes time that, when multiplied by the number of contraceptive prescriptions, constituted a significant workload.

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Table 1. Replies to the question 'How often would you do the following for your patients?' (n = 98).

	Frequency in months: 0	3	6	9	12	24	30	36	48	60
Blood pressure	3	1	68	10	16	0	0	0	0	0
Weight	35	3	21	0	35	1	0	3	0	0
Vaginal exam.	38	0	0	1	5	2	2	42	4	4
Breast exam.	52	1	0	0	24	2	1	15	1	2

References

1. Vessey MP. Oral contraception and health. *Br J Gen Pract* 1998; **48:** 1639-1640.
2. Hannaford PC, Kay CR. The risk of serious illness among oral contraceptive users: evidence from the RCGP's oral contraceptive study. *Br J Gen Pract* 1998; **48:** 1657-1662.
3. Owen-Smith V, Hannaford P, Webb A. What do family planning providers do before prescribing combined oral contraceptives? *Br J Fam Planning* 1996; **22:** 103-104.

Correction

Apologies are due for omitting part of the sentence in Curtis Jenkins and Tylee's letter published in the October issue of the *Journal* (p1700). This should have read, '40% of the patients had been referred on to outside agencies and that only 15% of all the patients seen by the counsellors in the study period were reportedly randomized.'

Please also note that the first line of the Results section in Stevenson *et al*'s Brief report (November *Journal*, p1771) should have read 'There was a total of 1067 consultations recorded. In 147 (13.8%) of the consultations…' and not '…417 (13.8%)…' as was stated in the *Journal*.

In the paper Development of a thyroid function strategy for general practice by S Ramachandran *et al* (October, pages 1683-1684), the following errors have been noted: in Figure 1 the box containing the value <20 should read >20, and the lower of the two boxes containing the value 10.1 to 20.0 should read 0 to 10.0; in line 2 of the Results the figure 4381 should read 4391.