though atherosclerosis and calcification were seen, intraluminal thrombosis was rare.[7]

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Research in general practice

Sir,

Dr Craddock's letter (February *Journal*, p.86) raises the issue of research by general practitioners. I agree with the view that research in general practice is both possible and worthwhile. Unfortunately, there may be a decline in the proportion of practices who are undertaking research.

I undertook a survey in 1982[1] and 124 of the practices in that study responded in the 1990 survey referred to by Dr Craddock.[2] In 1982, 39 of the 124 practices reported undertaking individual research of some kind, but in 1990 this number had fallen to 27. In 1982, 27 of the practices were taking part in some type of collaborative research, but in 1990 this figure had fallen to 19.

While this information is from a relatively small number of practices, if it does reflect a general trend, there is a depressing reduction in the proportion of general practices taking part in research. Possible explanations include the increase in pressure of work and changing attitudes among general practitioners towards research. This finding is worrying for those who wish to see general practice continue to develop a sound academic foundation. It is clearly important that further work be undertaken to confirm whether or not there is a genuine decline in research being undertaken by practices. If a decline is found, it is essential that the explanations for this are identified so that appropriate action can be taken.

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Postgraduate education

Sir,

We would like to respond to Dr Fox's criticism (May *Journal*, p.218) of our paper (January *Journal*, p.19). We were careful to report what the results showed and this was only that doctors who were members of a centrally organized educational scheme attended more educational meetings and that this applied for all categories of the postgraduate education allowance. Although we feel that the system is better educationally as it gives a more balanced spread of education we do not have the data to show this.

Dr Fox talks about education being a process whereby new skills and/or knowledge and/or attitudes are acquired which improve one's work and we could only agree with him. However, the literature on educational research in general practice is sparse. Fortunately this has been enhanced by the work from the west of Scotland. Dr Fox will be pleased to learn that we are currently looking at the effect of education on doctors in their day to day work.

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Quinine for night cramps

Sir,

In describing his crossover trial of quinine for night cramps (letters, March *Journal*, p.127) Dr Dunn states that 'this carry over effect suggests that withdrawal of quinine induces cramps. This is totally unexpected, and has not been reported before. Such an effect is difficult to explain.'

There were 14 patients in each group at the beginning of the trial, and a total of three dropped out. With such small groups it seems perfectly reasonable that the percentage of nights with cramp during the placebo period should be 65% in one group and 37% in the other. It only requires two or three individuals with severe symptoms to create this disparity.

If we look at the effect of quinine in each group we see that it reduced the incidence of nights with cramp from 65% to 27% in one group (58% reduction) and from 37% to 14% in the other group (62% reduction). This represents effective therapy in each group and in my opinion justifies the use of quinine for this condition.

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On-site physiotherapy

Sir,

Waiting list initiative money is being used in Doncaster to fund on-site physiotherapy in general practice. Twenty two of the 49 practices in Doncaster (45%) expressed an interest in establishing this service. Six practices have been funded to offer the service to their patients and Doncaster Health is keen to evaluate the initiative. Therefore Hackett and colleagues have produced a timely paper on the value of on-site physiotherapy in general practice (February *Journal*, p.61).

However, I am concerned about the different case mix in the three settings (one practice had on-site physiotherapy, one direct access and the third access only via orthopaedic consultants) and the fact that these were not taken into consideration in the analysis. The mix of diagnoses among patients in the practice with on-site physiotherapists differed significantly from that of the practice with access via orthopaedic consultants (chi square = 37.2, 7 degrees of freedom, $P<0.001$). On-site physiotherapy dealt with larger proportions of ankle ligament sprains and miscellaneous conditions and a smaller proportion of shoulder injuries. In particular, the higher proportion of prescriptions in the group with access only via a consultant may have been related to the case mix, thereby making the conclusion that ready access to physiotherapy may result in less drug prescribing a potentially misleading one?

The point made in the discussion that the practice with on-site physiotherapy had a rate of referral to physiotherapy of more than twice that of a practice with direct access is an extremely important one. Rates seemed higher for some conditions but particularly so for ankle ligament sprains and miscellaneous conditions. Beckerman and colleagues (February *Journal*, p.73) have demonstrated that there is as yet no proven benefit for treatment of many conditions with physiotherapy. It is not unusual to be undertaking

procedures in the National Health Service that have no proven benefit, but it is essential that we do not create new demand for these procedures.

Hackett and colleagues have undertaken a much needed study. However, when establishing on-site physiotherapy, consideration should be given to the size of the increase in referrals, the types and severity of conditions which result in increased referrals, the benefit gained from physiotherapy for these conditions and the effect on overall costs (it may be cheaper to undertake 100 procedures in general practice than 50 in hospital). This may allow general practitioners offering on-site physiotherapy to decide whether they should ration the service to particular conditions.

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Patients' liaison group

Sir,

The resolution of the General Medical Council to seek to amend the medical act 1983 to enable it to investigate cases of poor professional performance by doctors (editorial, January *Journal*, p.2), will be welcomed by all those concerned to promote an effective working partnership between patients and their general practitioners. As Sir Robert Kilpatrick argues, the present powers do not permit the GMC to conduct investigations into the day to day standard of professional performance of individual doctors, an area which is also largely excluded from investigations by the family health services authorities' service committees. Yet in practice, many of the cases concerning general practitioners about which there is an initial complaint to the family health services authority, or its Scottish equivalent, are about failures in communication. Being abrupt or inconsiderate to a patient is not a breach of the doctor's terms of service, but it can lead to real distress and the breakdown of any therapeutic relationship.

What is particularly frustrating to service committees about the present situation is not the inability to exact vengeance — most patients who complain argue that their main aim is to ensure that the same thing does not happen to someone else — but the inability to take any immediate effective action, particularly in the case of those offending repeatedly. A quiet word between the family health services authority and the local medical committee may sometimes prove effective with regard to practitioners who come to the repeated attention of the medical service committee, but the particular merit of the GMC's present proposal is the proactive response envisaged, offering counselling and training. The GMC is also to be congratulated, both on its willingness to involve lay input in the team of independent assessors and on the proposals to provide direct access to the 'preliminary screener' for individual patients, as well as health authorities and concerned professional colleagues.[1]

In the more vociferous and consumer oriented health service culture of the 1990s, it is to be anticipated that patients will become more assertive. Public expectations of the availability of general practitioner services are rising, their increased awareness of advances in medical technology is, according to the General Medical Services Committee, stimulating demands for a second opinion, and there is an increased tendency to look for someone to blame when things go wrong.[2] It is important that those of us, both lay and professional, who have the welfare of general practice at heart react constructively. Complaints procedures can be a key quality assurance strategy, identifying problems and promoting an effective dialogue to resolve them (Report of a review of the complaints procedure, GMSC 1992). The reputation of general practice remains high among its patients and it is important to encourage the least effective practitioners to strive for higher standards.

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Urine sampling technique

Sir,

Voided urine samples will always carry a high risk of being contaminated. Suprapubic aspiration of urine is the method of choice for obtaining a clean specimen, but most doctors rely on a voided sample for several reasons. According to our data, to obtain a clean-catch sample of urine, the most important step is to hold the labia apart during voiding.[1] Curtis and colleagues noted a sharp increase in the contamination rate of the first 22 urine samples taken after implementing our suggestions (letters, June *Journal*, p.260).

The full clean-catch midstream technique includes holding the labia apart, cleaning the periurethral area and using a midstream sampling technique. This sampling procedure can hardly be easier to understand or perform than just holding the labia apart, even for the obese, pregnant or frail elderly woman.

Does the routine method for urine sampling used by Curtis and colleagues comprise just two steps of the clean-catch midstream technique: to clean the vulval area and to obtain a midstream sample? Several studies have compared cleaning of the perineum with no cleaning, finding no difference in the contamination rate.[1-3] Is it possible that the benzalkonium chloride from the pads used by Curtis and colleagues may have contaminated the voided urine sample, thereby giving false negative results by reducing the bacterial growth in the sample?

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Journals for third world countries

Sir,

For several years I and others have been sending regular batches of back copies of the *British Medical Journal* (and sometimes other journals as well) to Dr Banks at the City Hospital, Nottingham. He forwards them to third world medical schools and hospitals which can ill afford to buy them. Perhaps readers of *The British Journal of General Practice* would like to consider passing on their recent back copies once they have finished with them. Dr Banks can be contacted at the Respiratory Medicine Unit, City Hospital, Hucknall Road, Nottingham NG5 1B.

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