a six-week intrauterine pregnancy and the second an asymptomatic ovarian cyst (7 cm diameter). Using a visual analogue scale to record the degree of discomfort caused by screening procedures, a bimanual vaginal examination did not cause more distress than breast examination or venesection. Ninety four per cent of women felt that a vaginal examination reassured them that all was well and 94.6% felt that it should be performed routinely, although 22.6% felt that it might put other women off attending.

In conclusion, it would appear that these women felt reassured that they had a healthy pelvis if a vaginal examination was performed at the same time as a cervical smear. As a group they were not unduly distressed by the examination and, as pathology may be detected, the opportunity to examine the pelvis digitally at cervical screening should not be missed. Either general practitioners should resume the practice of smear taking and combine this with a bimanual examination, or nurses responsible for cervical screening should be trained in performing the additional examination.

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Alternative contracts in the NHS

Sir,

A letter from Julian Tudor Hart[1] quotes from an article by Professor Maynard, Dr Marinker and me, published in the *British Medical Journal* in 1986, about the possibility of alternative contracts in the National Health Service.[2] Unfortunately, Tudor Hart has misrepresented the sense of that paper.

First, in terms of historical accuracy, it was Enthoven who first proposed a market approach.[3] His monograph was published the year before our article and we as professionals were examining what was then a new idea. The article to which Tudor Hart refers was the third in a series and its title raised as a question whether alternative contracts were viable.

In the first paragraph the exact words were: 'Here we examine five further options.' This makes it clear that the authors were in no way at that time advocating a managed NHS market; on the contrary, our exact words were: 'We conclude that the development of a good practice allowance, along the lines described in our previous paper[4] represents the best choice at this time for the public, the government, and the profession.' Furthermore we repeated this point in the final paragraph headed 'What option?': The opportunity exists to reform the present contract by adopting some variant of our own interpretation of the government's desire for a good practice allowance.

'It is not impossible that a system similar to HMOs [health maintenance organizations] may become the pattern for a future national health service. Implementing a good practice allowance now would give us invaluable experience in setting standards for primary health care, monitoring performance, and reviewing and maintaining progress. If this does not happen it is likely that some stronger and more radical medicine will be administered to the system of general practice in the UK.'

In hindsight it now seems clear that had the profession felt able to accept a good practice allowance which the Royal College of General Practitioners had proposed in 1985[5] and the government had offered the profession in 1986,[6] it would inevitably have had to be negotiated with the representatives of general practice. This would have been a more professional arrangement than the subsequent contract, which was imposed on the profession in 1990 and indeed formed the 'stronger and more radical medicine' which we feared in 1986.

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Patient involvement in medical education

Sir,

Jones and Oswald conclude that patients' attitudes are unlikely to present an appreciable barrier to increased medical student learning in general practice (letters, April *Journal,* p.184).

Patients in a recent qualitative study undertaken in our department were enthusiastic about involvement in medical education and some believed they could play a more active role, particularly in improving students' communication skills. All of the 26 patients interviewed expressed a willingness to take part in consultations where a student was present. A subsequent questionnaire study based on our results, carried out by medical students with 180 patients in Leeds confirmed our results (unpublished results). Both studies showed that patients perceive benefits for themselves and have few reservations.

Patients perceived the advantages of having a student present in the consultation as: helping to educate future doctors; learning more about their condition from the discussion between doctor and student; receiving a more thorough check up; interest in seeing the students' approach; and having someone uninvolved in their care to talk to (particularly if students visit patients at home). They saw the disadvantages as: potential embarrassment if the patient has a personal problem; feeling uncomfortable at being watched by the student; upsetting if the student appears uninterested; and the consultation may take longer.

Older patients (mostly those who had retired) in particular were enthusiastic about a more active involvement in student education. They had strong views about what students should learn, feeling that good listening, questioning and explaining skills were of paramount importance, along with the right attitude towards the patient (kind, respectful, not patronizing). This suggests that patients, in common with other potential community teachers,[1] would like a say in the sort of doctor that medical schools produce.

Thus, potential teachers, including health visitors, general practitioners, nurses and complementary practitioners would need to be involved in developing a curriculum which reflected the priorities, needs and ethos of primary care, rather than being expected to teach topics simply 'transferred' from the hospital. Realizing the potential for patient involvement in medical education clearly requires further work to identify the range of issues patients wish to see addressed, and appropriate teaching and learning methods.

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Complementary medicine

Sir,

I found Dr Brewin's editorial interesting (June *Journal,* p.243). His main point of criticism appears to have been the fact that the British Medical Association, and indeed the medical profession in general, is becoming over friendly with what he chooses to call 'fringe medicine'. I am not sure what he means by fringe medicine, but it is something which I would find hard to define, particularly as many activities previously considered to be fringe medicine, such as homoeopathy and acupuncture, are now widely available through the National Health Service.

Dr Brewin is attempting to shut the stable door after the horse has bolted. The increased interest in complementary medicine among both patients and doctors has already been demonstrated.[1,2] This interest has been expressed in the form of a realistic and constructive agenda by the British Medical Association.[3] One of the aims of such discussions is to attempt to define what could and should be integrated into patient care. This does not necessarily mean the medicalization of complementary practitioners or necessarily the skilling of doctors, but the constructive evidence-led integration of these two areas to the benefit of the patient.

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Sir,

I was dismayed to read an unsubstantiated attack on fellow health workers (editorial, June *Journal,* p.243). Dr Brewin should at least have defined the term 'fringe medicine' before sharing with us his opinion that 'Too much fraternization can confuse the public and suggest that we have lost confidence in rational thought and pragmatic problem solving.' Without such a definition it can only be assumed that he includes all complementary medicine, including those disciplines such as Chinese traditional medicine which have their own systems of aetiology, diagnosis and treatment.

Research suggests that many doctors view their patients' increasing use of complementary medicine as a lesson concerning the healing power, or lack of it, of modern western medicine, as well as suggesting the benefits of other therapies. Such research methodology involves listening properly to patients,[1] working cooperatively with other disciplines,[2] as well as randomized trials. Despite the difficulties of designing trials and valid outcome measures for complementary medicine, there is growing evidence of benefit, for example the use of osteopathy in back and neck pain,[3] homoeopathy in hay fever,[4] Chinese herbs in eczema[5] and acupuncture in disabling breathlessness.[6]

Increasing numbers of general practitioners, both in the United Kingdom[7] and elsewhere in the world[8] are learning complementary techniques themselves and referring patients to non-medical practitioners. The future would be better served by encouraging more cooperative research in this difficult field rather than adopting a closed mind.

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GPs and minor surgery

Sir,

Martin Letheren raises the point that local anaesthetic techniques form an important part of any training in minor surgery for general practitioners (letters, July *Journal,* p.377). I entirely agree with him. The members of the working party designing the courses I described in my editorial (March *Journal,* p.103) are very conscious of this. Indeed, a session on local anaesthesia has been an important part of the design of the course from the outset. This session covers the theoretical aspects of the subject as well as providing practical experience, using simulated tissue, along the lines of the other practical sessions.

Constance Martin and Marilyn Eveleigh raise an important point about the vital part played by nursing staff in the provision of minor surgery by general practitioners (letters, July *Journal,* p.378). I agree that infection control is an essential topic to cover. The course I described has included a session on this subject from the earliest stages of its design.

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Assessing medical performance

Sir,

We welcome the reaction of Brian Jolly and Lesley Southgate (letter, August *Journal,* p.379) which disputes our conclusion that 'the use of clinical notes to audit doctors' performance... is invalid.'[1] Their reaction is interesting since we believe their final conclusion is not different from ours, although they follow a different reasoning and, in our opinion, make a mistake in their reasoning.

They give two reasons for having doubts about our conclusion. They state that our study was biased both in type (new) and in content (lack of contextual attributes). In the first lines of the discussion we explicitly state 'Since... all patients were effectively new patients, one