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Reference

1. Seabrook M, Booton P, Evans T (eds). *Widening the horizons of medical education.* London: King's Fund, 1994.

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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References

1. Moore J, Phipps K, Marcer D, *et al.* Why do people seek treatment by alternative medicine? *BMJ* 1985; **280:** 28-29.
2. Wharton R, Lewith G. Complementary medicine and the general practitioner. *BMJ* 1988; **292:** 1498-1500.
3. British Medical Association. *Complementary medicine: new approaches to good practice.* Oxford University Press, 1993.

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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References

1. Sharma U. *Complementary medicine today: practitioners and patients.* London: Routledge, 1992.
2. Pietroni PC. Beyond the boundaries: relationship between general practice and complementary medicine. *BMJ* 1992; **305:** 564-566.
3. Kos BW, Bouter LM, van Mameren H, *et al.* Randomised clinical trial of manipulative therapy and physiotherapy for persistent back and neck complaints. *BMJ* 1992; **304:** 601-605.
4. Reilly DT, McSharry C, Taylor MA, Aitchison T. Is homeopathy a placebo response? *Lancet* 1986; **2:** 881-886.
5. Sheehan M, Atherton DJ. Controlled trial of traditional Chinese medicinal plants in widespread non-exudative atopic eczema. *Br J Dermatol* 1992; **126:** 179-184.
6. Jobst K, McPherson K, Brown V, *et al.* Controlled trial of acupuncture for disabling breathlessness. *Lancet* 1986; **2:** 1416-1419.
7. Anderson E, Anderson P. General practitioners and alternative medicine. *J R Coll Gen Pract* 1987; **37:** 52-55.
8. Hadley CM. Complementary medicine and the general practitioner: a survey of general practitioners in the Wellington area. *N Z Med J* 1988; **101:** 766-768.

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