TYRRELL EVANS
MARY SEABROOK

Innovation in Medical Education Project
Department of General Practice and Primary Care
King's College School of Medicine and Dentistry
Bessemer Road
London SE5 9PJ

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.

GEORGE LEWITH

The Centre for the Study of Complementary Medicine
51 Bedford Place
Southampton
Hampshire SO15 2DT

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.

CHARLOTTE PATERSON

Warwick House Medical Centre
Upper Holway Road
Taunton
Somerset TA1 2YJ

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.

R L KNEEBONE

Lovemead Group Practice
Roundstone Surgery
Polebarn Circus
Trowbridge
Wiltshire BA14 7EG

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

should be careful when generalizing beyond the specific sample of cases in this study'. Indeed in his experiments (in which accidently J-J R was one of the doctors studied) Hobus showed that contextual factors are important in diagnosis.[2] However, Hobus also confronted the doctors with new patients.[2]

Jolly and Southgate ask what performance is. We define performance as what a doctor actually does in day to day practice, preferably in a setting where doctors are unaware they are being studied.[3] Also, performance (and thus its assessment) may be divided in several aspects (for assessment thus several methods) as for example the personal interaction between doctors and patients, the medical technical content of a consultation and the record (clinical notes) of a consultation. Indeed we believe that our correlations should be regarded in the same way that multiple choice questions and clinical scores correlate in formal assessment systems. Therefore we state that 'the use of clinical notes to rank doctors according to those who perform many or few actions... may be justified' and, indeed, criterion validity is not addressed here. Jolly and Southgate suppose that a correlation coefficient of 1.0 would imply that every action would have been recorded, irrespective of its importance and ask whether this is sensible. No, it is not sensible. We do not believe (and thus we agree with them) that every action has to be recorded or that a record has to be verbatim of the consultation. However, that is not what a correlation of 1.0 is about, since if all doctors noted 20% (or 30% or 50%) of their actions and thus presumably took quality of actions into account, then the correlation would still be 1.0.

So, indeed from the range in mean content scores in our study little can be concluded from records about what doctor actually do during consultations. If however, records are being used as one in a series of performance assessment methods, records review may well prove to be valid, since it may correlate with other aspects of performance. For example, to study recording habits (as an aspect of performance), clinical notes may well be studied. However, to look at the actual content of consultations clinical notes, with the restrictions from our discussion section in the paper, should not be used.

JAN-JOOST RETHANS
ERIC MARTIN
JOB METSEMAKERS

Department of General Practice
University of Limburg
Postbus 616
6200 MD Maastricht
Netherlands

References

1. Rethans J-J, Martin E, Metsemakers J. To what extent do clinical notes by general practitioners reflect actual medical performance? A study using simulated patients. *Br J Gen Pract* 1994; **44:** 153-156.
2. Hobus P. *Expertise van huisartsen: praktijkervaring, kennis en diagnostische hypothesevorming* [Expertise of general practitioners: content in diagnostic hypothesis formation, PhD thesis]. Maastricht, Netherlands: University of Limburg, 1994.
3. Rethans J-J, van Leeuwen Y, Drop R, *et al.* Competence and performance: two different concepts in the assessment of quality of medical care. *Fam Pract* 1990; **7:** 168-174.

Counselling children in general practice

Sir,

I entirely agree with Wright and Cottrell's reply (August *Journal,* p.380) to an editorial on counselling.[1] Unfortunately, most counselling and psychotherapy training in the United Kingdom does not address the training issues of working with children and families.

Traditionally, most medical child psychotherapists worked from an analytical and psychodynamic perspective and their training is long and expensive. However, this is slowly changing as family systems theory is beginning to inform effective practice. Unfortunately, the number of trained therapists is tiny and only a very small proportion work in general practice in the UK.

Until training improves, it is probably wise that counsellors continue to work with patients aged 16 years and over, in order to prevent harm and be cost effective. Also, the picture many general practitioners share of traditional child guidance clinics with their long waiting lists may colour their attitude to providing such a service in-house.

To work effectively with children and their parents demands great skills and sensitivity together with the ability on the part of therapists to build up trust with their patients. General practice, with its tradition of continuing care lends itself ideally to the establishment of such services. Interested general practitioners running child health surveillance programmes, and skilled health visitors, are at present carrying much of the burden, often uncontained, unsupported and inadequately supervised.

All this will change as more counsellors working in general practice are trained to work using a family systems perspective and have in their tool box of skills cognitive behavioural strategies that they can apply successfully, as well as the wider counselling perspective that their training brings.

GRAHAM CURTIS JENKINS

Counselling in Primary Care Trust
Suite 3a
Majestic House
High Street
Staines TW18 4DG

Reference

1. Salinsky J, Jenkins GC. Counselling in general practice [editorial]. *Br J Gen Pract* 1994; **44:** 194-195.

Occupational therapy

Sir,

In Cambridge, the National Health Service community trust (Lifespan Healthcare) has not only undertaken to raise awareness of the full potential of occupational therapy for primary care, but has also recently received a grant from the Headly Trust to develop a model occupational therapy service based in general practitioners' surgeries and accessible by direct referral from any member of the primary care team. While the College of Occupational Therapists[1] and many fundholding practices[2] are considering new roles for these therapists, the benefit of any specific service offered is unknown. We hope to evaluate systematically the contribution NHS occupational therapists could make in this new setting, based on our experience with outcomes of occupational therapy for inpatients[3] and day patients.[4] However, before framing our intensive evaluation (involving a limited number of practices) it would be invaluable to have comments from general practitioners on their experiences of working with occupational therapists in the surgery. We would be most grateful if readers could send such comments to the address below.

WOODY CAAN

Lifespan Healthcare
Second Floor
Douglas House
18b Trumpington Road
Cambridge CB2 2AH

References

1. College of Occupational Therapists. *Who makes doctors better?* London: College of Occupational Therapists, 1993.
2. Ingram S. Reference guide — occupational therapy. *Fundholding* 1994; **3**(8): 25-28.
3. Harries P, Caan W. What do psychiatric inpatients think about occupational therapy? *Br J Occupational Ther* 1994; **57:** 219-223.
4. Rutherford J, Caan W. User satisfaction with a psychiatric day hospital. *Psychiatr Bull* 1993; **17:** 627-628.