aging grief reactions among patients. To this end the protocol has much to commend it. General practitioners will find many of the suggestions appealing and may wish to incorporate them into their own guidelines.

Before we adopt such a policy unreservedly, however, it is important to consider the dangers of overmedicalizing grief. Grief can be considered a normal part of ageing.[1] The more the medical profession become involved in bereavement, the more it takes on the connotations of a disease.[2] The resulting medical responsibility could have sociolegal consequences. It may, for example, weaken patients' existing supportive social constructs. This could have implications beyond the immediate bereavement, as society learns a new model for coping. On an individual level, it could also limit the person's emotional growth that can come from grief.[3]

Given these concerns, it is imperative that any future protocol has clearly defined benefits. This is achievable, given the evidence for bereavement counselling, although we must remember that this research has been based in non-primary care settings.[4] Also, in order to facilitate successful counselling, there is an advantage in planning care according to a risk assessment. This can be performed by applying forms used in hospices.[5] There may be some benefit from delaying this assessment until the rituals of death are complete, when the bereaved patient's true vulnerability may be more apparent.

An additional concern relates to applying a uniform approach to what is a highly individualized, complex psychological phenomenon. A bereavement protocol has to respect this by being versatile. The protocol suggested by Charlton and Dolman allows the general practitioner an individually tailored response to a bereaved person. However, it should also ensure that it fully complements existing professional and social care. A combination of a risk assessment and an awareness of all the follow-up options will facilitate appropriate intervention. Such an approach perhaps needs to be incorporated into the protocol. This desire for versatility needs to be considered for any written material used. Care needs to be taken in its preparation and piloting, as this information must be presented in a form helpful to the general public.

Grief has considerable health implications that require the attention of primary care. However, any approach to the problem of such implications has to have clear benefits and be sensitive to the social context of bereavement. In order to answer these anxieties there is a need to expand the limited research into bereavement and bereavement support in primary care, particularly in the evaluation of any proposed innovations.

RICHARD WOOF
YVONNE CARTER

Department of General Practice
The Medical School
University of Birmingham
Edgbaston
Birmingham B15 2TT

References

1. Cummings E, Henry WE. *Growing old.* New York, NY: Basic Books, 1961.
2. Averill JR, Nunley EP. Grief as an emotion and a disease: a social–constructionist perspective. In: Stroebe MS, Stroebe W, Hanson RO (eds). *Handbook of bereavement.* Cambridge University Press, 1993.
3. Schnieder J. *Stress, loss and grief.* Baltimore, MD: University Park Press, 1984.
4. Parkes CM. Bereavement counselling: does it work? *BMJ* 1980; **281:** 3-10.
5. Wilkes E. Characteristics of hospice bereavement services. *J Cancer Care* 1993; **2:** 183-189.

Sir,

The paper by Charlton and Dolman discussing the use of a bereavement protocol in primary care (August *Journal,* p.427) appears to omit one important date of contact between a general practitioner and his or her bereaved patient. This is between six and eight weeks after the event, when the relatives, counsellors and others have gone their way and the bereaved person is having to face life as it really is, alone. This date has the added merit of being one by which psychotic depression, as opposed to justifiable misery, is relatively obvious, relatively common, but entirely treatable.

JOHN STRUTHERS

27 Kellett Road
Southampton SO15 7PS

GP–patient social and sexual contact

Sir,

I was interested in the article by Coverdale and colleagues on social and sexual contact between general practitioners and patients (May *Journal,* p.245) because of its importance and because I was one of the doctors who replied to the questionnaire. Two aspects of the study are open to criticism.

No distinction was made between general practitioners working in rural and urban areas, between single and married general practitioners and between single and married patients. There is a vast difference between a single general practitioner working in a rural area who has to suture a cut finger of a young woman patient whom he then meets socially in the community (they are attracted and marry or become lovers); and a married general practitioner working in a city who seduces a patient who has attended him for counselling about an unsatisfactory marriage. More useful information could have been gained from the study if general practitioners had been asked to judge perhaps six such scenarios.

The other criticism is that there was no way of distinguishing how the general practitioner respondents in the study had learned about sexual contacts between other general practitioners and patients and whether reported cases were public knowledge. The three cases known to me were general practitioners whom I knew personally and whose names had been published in the *New Zealand Medical Journal.*

I hope that this important study is not taken as a baseline against which to measure any future changes but that it is considered as a pilot study from which comes further work on what many would see as one of the most serious breaches of trust between doctors and their patients.

JOHN MEIN

43 Stewart Street
Waikouaiti 9063
New Zealand

Complementary medicine

Sir,

I would like to comment on the letter from Ernst and colleagues (September *Journal,* p.506) which gave a definition of complementary medicine. Many doctors besides me must have long been puzzled by the need for such a definition. A definition of complementary medicine would be unnecessary if the discipline of medicine itself were properly defined as 'the study of human ailments and of the methods employed for their prevention and treatment'. All ailments, preventive strategies, diagnostic procedures and treatments must then be subject to the scrutiny of the one inclusive discipline. All effective preventive strategies, diagnostic procedures and treatments are subjects of medicine and

should be included in the curriculum of medical students.

Numerous orthodox strategies and treatments are still awaiting adequate investigation and justification, as is the case with many of the so-called complementary therapies. The same rigorous study should apply to both orthodox and complementary medicine, so why the need for the division? If a therapy is found to be effective it is automatically a part of medicine. If a suggested therapy is found to be ineffective, it is not medicine. There is no advantage, and much disadvantage, for progress in the art and science of medicine in maintaining such a meaningless division. Is it too late to revert to the unitary approach that is so necessary for the health of medicine itself?

R EDGAR HOPE-SIMPSON

12 Corinium Gate
Cirencester
Gloucestershire GL7 2PX

Sir,

I was fascinated by Ernst and colleagues' letter (September *Journal,* p.506) defining complementary medicine. However, their definition depends intimately on a definition of orthodoxy. Examined carefully it would appear that acupuncture practised in a conventional medical setting (for example a pain clinic or physiotherapy department) might be defined as orthodox treatment, particularly if it only involved inserting needles into painful tender points on the patient's body. I feel sure that many physicians would have difficulty accepting a definition of complementary medicine that could lead to the practice of acupuncture being classed as orthodox.

GEORGE LEWITH

School of Medicine
University of Southampton
Southampton General Hospital
Tremona Road
Southampton SO16 6YD

Counselling and psychotropic drug prescribing

Sir,

Fletcher and colleagues (September *Journal,* p.467) suggest that the findings from their paper indicate that 'providing more counselling in general practice is unlikely to be funded from savings in prescribing psychotropic drugs'. Unfortunately, we believe their conclusions are untenable for the following reasons.

Many studies have shown reductions in the prescribing of psychotropic drugs after counselling interventions with individual patients.[1,2] Only when patients can be tracked through referral for counselling treatment and follow up can the effects be detected. This was not done in Fletcher and colleagues' study. Neither the dilution effects of individual general practitioner referral patterns (which can vary 10-fold between partners in the same practice[3,4]) nor the individual prescribing habits of referring general practitioners (which can have major effects on prescribing costs) were taken into account.

Two questions remain unanswered. First what effect do general practitioners' attitudes to psychological distress and mental illness have on their prescribing habits, costs and referral patterns to counsellors? Secondly, how can general practitioners maximize the effects of counselling interventions in general practice? These questions urgently need answers before further studies such as this are reported and before claims that counselling affects prescribing costs on a practice-wide scale are made.

When general practitioners and counsellors work collaboratively and when a counsellor's work is specifically targeted and focused in a way that encourages patients to learn how to use non-drug strategies to manage and alleviate their psychological distress, changes in psychotropic drug prescribing are likely to occur across an entire practice. Until that time, only changes in individual patient's costs are likely to indicate that the counselling intervention has had the effect studied.

GRAHAM CURTIS JENKINS

Counselling in Primary Care Trust
First Floor, Majestic House
High Street
Staines TW18 4DG

ADRIAN HEMMINGS

Trafford Centre for Medical Research
University of Sussex
Falmer
Brighton BN1 9RY

References

1. Boot D, Gillies P, Fenlon J, *et al.* Evaluation of short term impact of counselling in general practice. *Patient Educ Counselling* 1994; **24:** 79-89.
2. Spiers R, Jewell JA. One counsellor, two practices: report of a pilot scheme in Cambridgeshire. *Br J Gen Pract* 1995; **45:** 31-33.
3. Hemmings A, Cogan M. *Non-pharmacological management of anxiety.* London: South East Thames Regional Health Authority, 1993.
4. Harvey I. *Counselling in general practice. The results of a randomised controlled trial.* South Glamorgan: South Glamorgan Family Health Services Authority, 1995.

Information leaflets on contraception

Sir,

In their paper (August *Journal,* p.409), Smith and Whitfield found that providing Family Planning Association information leaflets (*The combined pill, The progesterone-only pill* and *Emergency contraception*) improved patients' knowledge both of taking oral contraceptive pills correctly and of emergency contraception.

We undertook a survey comparing the efficacy of information leaflets in addition to verbal advice with that of verbal advice alone, in educating women on the correct action to take when a contraceptive pill is missed.[1] Although our study showed the superiority of information leaflets and verbal advice over verbal advice alone, we were not as impressed as Smith and Whitfield were on the efficacy of information leaflets.

Our study found that one year after receiving advice, only 18 of 88 users of the combined pill (20%) given information leaflets plus verbal advice were able to describe the correct action to take in the event of missing a pill. The corresponding figure was two of 88 combined pill users (2%) who were given verbal advice alone. The difference was significant, chi square = 12.7 ($P<0.001$).

Nine out of 14 users of the progesterone-only pill (64%) who received leaflets plus verbal advice were able to describe the correct action to take if a pill was missed, compared with six out of 20 in the group receiving verbal advice alone (30%). This difference was not significant; however, the numbers were small.

We concluded that although the study showed that information leaflets were effective, their effect was modest. It was interesting that in Smith and Whitfield's paper, at the end of the study (three to 12 months later) only 25% of respondents knew about the 'seven-day rule', again a disappointingly low figure.

The authors state that the most important reasons for unplanned pregnancies concerned lack of knowledge about contraception. A survey in our practice, however, found that the most important reason for unplanned pregnancies was patients' fear of side effects from the contraceptive pill.[2]