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

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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]