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?

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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.

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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.

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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]

The Family Planning Association leaflets are excellent, giving accurate advice and a balanced picture of the health implications of taking hormonal contraceptives.

Smith and Whitfield's study perhaps confirms our fears that even if a patient has been given an information leaflet, she will probably still not take the correct measures if she were to miss the pill.

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Diphtheria

Sir,

I read with interest Martin's editorial on diphtheria (August *Journal,* p.394), which gave an excellent summary of its epidemiology, management and prevention. The current epidemic in the countries of the former Union of Soviet Socialist Republics (USSR), together with the increased travel to that part of the world, has certainly refocused attention on this potentially fatal infectious disease. I have a number of points to add to those stated in the editorial.

First, general practitioners will be interested to know that a single antigen diphtheria vaccine for adults is available. Although the combined adult diphtheria/tetanus vaccine is usually an acceptable alternative for adults requiring diphtheria immunization, it cannot be administered to patients who have had a previous severe reaction to tetanus immunization.

Martin stated that all close contacts of patients with diphtheria should be prescribed antibiotic prophylaxis, without waiting for their swab results and irrespective of their vaccine status. Although I tend to agree with the author, it is worth pointing out that others have argued that only those close contacts who are inadequately immunized or who have positive swab results should receive prophylaxis.[1,2] It is also useful to define who should be considered a close contact. The list includes: household members, friends/relatives/carers who regularly visit the home, kissing/sexual contacts, school classroom contacts, those who share the room at work and health care staff exposed to oropharyngeal secretions of the patient.[3] These close contacts should be kept under daily surveillance for at least seven days after the last contact with the patient. Surveillance should include inspection of the throat for the presence of a membrane and measurement of temperature.[3] Contacts should be considered clear when a minimum of two negative nose and throat swabs have been obtained, at least 24 hours apart, beginning at least seven days after the last contact with the case or carrier and at least five days after completion of any antibiotic prophylaxis.[1] Close contacts whose swabs are positive should be excluded from handling food and from work with schoolchildren until bacteriological clearance is obtained.

The World Health Organization has recommended that coverage levels should exceed 95% of infants receiving three diphtheria immunizations by the age of two years.[3] However, like many other historically important infections, there is a danger that the rarity of diphtheria in the United Kingdom could lead to complacency. Therefore, the importance of public education on the need for immunization (both routine and travel-related) cannot be over-emphasized.

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Practice nurse workload

Sir,

In their paper on practice nurses' workload and consultation patterns (August *Journal,* p.415) Jeffreys and colleagues raised some interesting issues, but I felt that the study was too focused on the tasks performed rather than considering all aspects of a patient's needs.

In my own research, as yet unpublished, I audiotape recorded practice nurse consultations and subsequently analysed them, attempting to replicate the work of Byrne and Long.[1] The 'task', for example the dressing of a wound or the taking of a blood sample, proved to be the pivot or focus of the consultation with nine other categories of intervention interwoven throughout. The most frequently occurring were: education and explanation; building the patient–nurse relationship; and health promotion.

The practice nurse, because of experience and extended training, is able to make assessments of a patient, understand the clinical significance of findings and when necessary seek appropriate medical advice for the patient or refer to other professionals. It is these elements which I believe contribute greatly to the quality of patient care and might be lacking if a health care assistant were to undertake some of these aspects of patient care, as proposed in the paper by Jeffreys and colleagues.

Delegation of form filling, patient recall systems, computer skills and routine clerical tasks would be more appropriately undertaken by non-medical staff. I envisage practice nurse teams comprising a mix of skills with different levels of training, interests and clinical skills, more integrated with community nurse colleagues, and also continuing to share with general practitioners the care of patients with diseases such as asthma, diabetes and hypertension.

I am sure that it is right to look at the practice nurse workload and delegate wherever possible to appropriately trained personnel, although I have reservations about the employment of health care assistants to perform tasks such as blood sampling and blood pressure measurement.

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Re-education via Darwinian medicine

Sir,

Medical teaching would be revolutionized if greater attention were paid to Darwinian