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Chlamydia infection in women

Sir,

In their review article, Oakeshott and Hay (November *Journal,* p.615) fail to discuss a number of important issues relating to the management of women with cervical chlamydia infection in general practice.

Firstly, they state that women diagnosed with cervical chlamydia infection in general practice should be treated and referred to a genitourinary medicine (GUM) clinic for follow-up. It is often argued that all cases of genital chlamydia should be referred to GUM clinics on the grounds that the necessary contact tracing can only be provided in this setting. The only published systematic review of studies looking at partner notification strategies concludes that, as far as chlamydia is concerned, there is conflicting evidence regarding the effectiveness of provider referral (contact tracing partners directly) compared with patient referral (asking the patient to inform his/her partner of the need for diagnosis and treatment).[1] Therefore, we do not know if contact tracing by general practitioners would be less successful than that currently performed by GUM clinics.

Secondly, they argue that many women can be persuaded to attend a GUM clinic if they are given an adequate explanation, and communication between general practitioners and local GUM consultants is good. A literature search revealed no qualitative research exploring the views of patients about sexually transmitted diseases and their management nor any studies describing why patients with a sexually transmitted disease choose to visit a particular clinic or general practice surgery. This question is not merely of academic interest. For example, if one screens for chlamydia in primary care at the same time as a cervical smear, and women who test positive have to attend a GUM clinic for treatment and follow-up, then one needs to know if such women view attending a GUM clinic as acceptable. They might prefer to be treated in primary care.

Thirdly, they suggest that the management of chlamydia by GPs without a research interest in genital chlamydia would be less complete than that offered by GUM clinics. The only published research to address this problem comes from Canada,[2] where researchers found that, despite the availability of recently published national guidelines on the management of STDs, there appeared to be important gaps in the knowledge and practice of many Canadian primary care physicians with regard to genital infections. Therefore, research is needed to determine how GPs manage genital chlamydia, how they view GUM clinics and what their referral policy might be.

In conclusion, we agree with the authors that GPs and practice nurses have an important role to play in reducing the prevalence of cervical chlamydia infection and its serious consequences.

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General practice research

Sir,

Bruce Arroll (February *Journal,* 124) continues the debate on appropriate training for general practice research. He concludes by advocating the supervised MSc and PhDs in preference to an unsupervised MD.

I have developed an interest in research during my 16 years as a GP principal despite a lack of supervision or research training. Therefore, I wish to describe the advantages of the unsupervised approach in contrast to Dr Arroll's letter.

The unsupervised approach encourages development of clinical observation and research *in general practice* rather research *on general practice.* I developed the slightly obscure clinical interest of diving medicine into a subject for case descriptions and treatment protocols which stood up to external peer review in authoritative journals.[1-6] I feel this should encourage GPs to realize that they can still know a great deal about small, defined areas of clinical medicine and make original contributions to knowledge.

I had always wanted to climb the academic mountain and plant my MD flag on the top. Chance intervened but I had to make a change of tack from diving medicine when I was lucky enough to come across a new cause of occupational asthma. I went on a distance-learning occupational medicine course which included epidemiology and statistics. I spoke with a couple of friends in the discipline who warned me about GPs who had been trampled in the rush by academic departments to investigate interesting factories. Therefore, I had to take a calculated risk to maintain control and ownership of the project to proceed into the unknown. My best advice came from my immunologist colleague who is not a clinician. I designed a cross-sectional survey with a nested case control study of the factory in order to test my hypothesis that I was observing a new variation of an old illness.

I attended academic conferences to hear research registrars in respiratory medicine make a meal ticket out of one case of occupational asthma. I kept quiet about my 291 subjects and 24 cases who they would have given their right arms for.

Some might judge my gamble foolish as there was a risk that my study design could have been fundamentally flawed. However, when I finally presented my MD after 5 years, the two examiners of international status, who had written books on the subject, passed it without question.[7]

In conclusion, I feel it would be a shame if the MD degenerated into yet another meal ticket. It should remain a flexible, personal statement for doctors who wish to take as long at they want to conduct their research *in general practice* rather than *on general practice.* If people want supervision for an MD, there are plenty of people to offer advice if they need it. Original ideas for research pro-

jects can be 'poached' by the unscrupulous.

Research in general practice is about independent thinkers who can stand on their own feet despite the slings and arrows of professional life. I would suggest leaving the PhD for Pretty hospital-orientated Doctors who wish to be spoon fed with the meal ticket required to climb an ivory tower.

Let's keep the MD for the Maverick Doctors who graze in the grass roots of general practice and gaze at distant academic mountains. Only fools go into the mountains without knowing how to use a map and compass. First climb a few small hills with a trusted friend[8,9] before tackling an unconquered peak. However, getting to the top without a professional mountain guide is part of the satisfaction, and not entirely foolhardy — mountain guides can get avalanched too.

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Complementary medicine

Sir,

Professor Ernst (February *Journal,* p.60) correctly identifies the burgeoning interest in, and provision of, complementary medicine in British primary care, but his demand that we base our practice on results of randomized control trials (RCTs) is not a realistic one. Conducting an RCT, with its requirement for large samples of homogeneous patients, is an uphill struggle for GP researchers, and few have yet been reported.

I have recently completed a survey which adds new information about the growth of complementary medicine in primary care. In January 1996, a questionnaire was mailed to the practice managers of all 72 practices on the list of Somerset Family Health Services Authority. The questionnaire defined complementary practitioners as including: *'acupuncturist, homeopath, osteopath, chiropractor, masseuse, healer, reflexologist, herbalist, Alexander technique teacher ... and any other therapists you feel fall into this diverse group.'* The first question asked whether the practice was fundholding. The second asked for a response it *'the practice has no connections with complementary practitioners'.* The third question was in the form of a table of various types of practitioners, and three different types of availability, and respondents were asked to tick the boxes which described their practice.

Fifty-nine questionnaires were returned completed (82%) and only 22 (37%) indicated they had no connection with complementary practitioners. The 37 practices (63%) describing a connection showed a wide variation in the number and type of complementary therapies that were available, and in the mix of availability in the NHS and private sector (see Table 1). The majority of these practices provided complementary therapies privately, either in or alongside the surgery. However, in 16 practices (27% of respondents), one or more type of therapy was available on the NHS. There was commonly a mix of provision. Sixteen (27%) of the practices were fundholding, and fundholding status made no apparent difference to the provision of complementary medicine.

Table 1. Availability of complementary medicine in 59 respondents.

Type of practice	Available on NHS to some patients within your surgery*	Available privately to patients within your surgery*	Available privately alongside but separate from your surgery*	Other	None
Fundholding (n = 16)	5	5	6	3	5
Non-fundholding (n = 43)	11	78	9	2	17
Total (all practices)	16	13	15	5	22

*Respondents could indicate more than one of these four columns.

Acupuncture, osteopathy, homeopathy and chiropractice were the four commonest therapies, in that order, both on the NHS and privately, and were provided at least twice as often as the others.

The RCT is a good research design for providing the evidence needed in the biomedical paradigm: where one drug/intervention in one specific biochemical/genetic condition in a 'blinded' and non-involved patient produces a particular result. However, it is not useful in evaluating a treatment where the patient is an active partner in treatment and where the patient's mind, body and spirit are all involved in the healing and homeostatic processes. In exploring new and alternative ways of understanding the human body and it's diseases, we need research which generates new hypotheses. Qualitative research into patients' needs and experiences of complementary medicine in practice are all methods for which general and complementary practitioner researchers have excellent opportunities. Now, with evidence of increasing integration of therapies at a primary care level, there is opportunity for very exciting research which may eventually provide new insights into the conundrums of technical medicine.

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