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## Low back pain services

Sir,

A striking aspect of the brief report by M R Underwood *et al* (June *Journal*) is the astonishingly high response rate. Certainly, the results reveal a decidedly unsatisfactory state of affairs from the patients' points of view; weeks of inaction are just not to be condoned, yet what I find difficult to understand is the logic of the suggestion in the penultimate paragraph: 'Any campaign to improve services for low back pain should therefore target service provision in hospitals.' Not only is this contrary to the Clinical Standards Advisory Group (CSAG) guidelines,<sup>1</sup> but it is also inevitably a recipe for increasing the already wholly unacceptable waiting times.

Where I disagree with the recommendations made by the CSAG is in the apparently acceptable delay before treatment of simple back pain is initiated. Surely the ideal answer must be to offer potentially useful therapy on initial presentation of the problem, or at least within a very few days of this. This may be readily achieved in primary care; first the GP makes the local examination mandatory for proper assessment, then, in the majority of cases, he either proceeds himself with his chosen therapy on the spot (incidentally saving himself some expense), or he refers the patient for treatment by physiotherapist, osteopath, or chiropractor — preferably 'in-house'.

Local examination of the back (in addition to what is commonly regarded as orthodox) is fundamental to dealing adequately with these problems. It need take no more than four minutes. Vertebral manipulation (a commonly effective therapeutic option) may be performed in one minute without resorting to dubious hypotheses.<sup>2</sup> For the doctor with appropriate skills, the latter takes no more time than arranging referral, either within primary care or adding to outpatient overload. His reward is twofold: a frequently

rapid return to normal life for the patient, and a sharp decline in his total consultations for low back pain. It does not add to his workload and it may save him and the tax-payer money.

With intensive use of the appropriate manual,<sup>3</sup> the necessary skills to implement this may be learned in three concentrated practical sessions. This is now offered as an integral part of orthodox rheumatological postgraduate training and is available to all interested GPs. Apart from the substantial benefit accruing to a large proportion of patients, the attainment of such skills further results in a reduction in outpatient demand, and also of the unacceptable waiting lists that are common today.

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## Patients' voices at the AUDGP

Sir,

This year's Annual Scientific Meeting of the Association of Departments of General Practice (AUDGP), attended by over 400 participants, was hosted with efficiency and style by the departments of general practice in Ireland. As a novice to the occasion, I valued the opportunity to see and hear well-known but previously unmet academics, to meet other researchers whose work is of particular interest to me, and to enjoy the company of friends in the heart-warming city of Dublin. The choice of six parallel sessions of high-quality papers on a wide variety of topics, where research methodology was always under scrutiny, was very stimulating, and it led to new insights and lessons as well as some new research evidence to be applied in my own practice. However, another participant's question, during a session on narrative research, raised a doubt in my mind. The question was, 'Where are the patients' voices in all this?'

Peoples' voices only get heard through qualitative research. The conference had opened with a stunning presentation of qualitative research into homeless people,

and I felt that qualitative papers were quite prominent at the conference. On the other hand, much of this work allowed *our* voices to be heard, rather than the patients'. As I sat in the airport departure lounge I scrutinized the papers. Of a total of 96 freestanding papers (excluding workshops, posters, and the debate), 24 were on qualitative research likely to allow voices to be heard; i.e. they provided qualitative analysis of transcripts of interviews, focus groups, consultations, or observation. However, only 13 of these included the patients' views, rather than the health care workers' or students'. Everyday practice gives rise to so many fascinating research questions; how should we decide which ones to pursue? And, as the health care workers closest to the patient — their main providers, their advocates, and their long-term healers — is an allocation of 13% enough?

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**Correction:** In the September issue of *Connection* (page VIII), Dr Edward Hamlyn's telephone number was misprinted. It should have read: 01752 892792.