

Influenza ear? <i>R Muirhead</i>	584	<i>B McKinstry and J Walker</i>	585	Intuition, creativity, dialogue, tacit knowledge and ... evidence?
Cataract: a pre-referral protocol <i>C Champion-Smith</i>	584	Chronic fatigue syndrome <i>C Clark</i>	586	<i>Martin Quinn</i>
Abdominal aortic aneurysm <i>I Shergill and D Bose</i>	584	Prescribing costs and patterns: authors' response <i>J Walker and N Mathers</i>	587	All letters are subject to editing and may be shortened. Letters should be sent to the <i>BJGP</i> office by e-mail in the first instance, addressed to <a href="mailto:journal@rcgp.org.uk">journal@rcgp.org.uk</a> (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.
'Homelessness and Health' conference <i>A Wilson</i>	585	Commentary on the EBOR trial report <i>N Freemantle, I Nazareth, J Wood, A Haines, and M Eccles</i>	587	
Response shift, responsiveness or recall bias? <i>M Robling and K Hood</i>	585	Screening for atrial fibrillation <i>J Cox and E Roderick</i>	588	
GP telephone consultations				

## Influenza ear?

I am writing to report a strange phenomena that our practice nurse has identified in patients who have been vaccinated with 'flu vaccine this year and wonder whether anyone else has noticed a similar complaint.

It appears that numerous vaccinated patients have been consulting with intermittent, mild ear irritation. It feels like a eustachian blockage with canal pruritus. It can be resolved with decongestant medication but relapses for up to three weeks afterwards. Aural examination occasionally reveals excoriation of the canal.

I presume this is a reflection of mild mucosal inflammation secondary to the 'flu virus but had not come across it before. I would be interested to hear from others who have had a similar experience. E-mail: [scotdoc\\_59@hotmail.com](mailto:scotdoc_59@hotmail.com)

RUSSELL MUIRHEAD

Audlem Medical Centre CW3 0AH.  
E-mail: [Russell.Muirhead@gp-N81001.nhs.uk](mailto:Russell.Muirhead@gp-N81001.nhs.uk)

## Cataract: a pre-referral protocol

I welcome Menon and Patrick's suggested protocol (although I would prefer the term guideline, accepting that there will always be exceptions) for visual function assessment.<sup>1</sup>

However, it is important to ensure that general practitioner (GP) time is spent on activities that require critical thinking rather than simple tasks.

I suggest a locally agreed pathway, incorporating the suggested functional assessment, where the optometrists carry out the functional as well as technical assessment of vision. The optometrist could refer the majority of patients fulfilling agreed criteria directly

to the local ophthalmology service, while only directing those, where there are issues of other medical problems or the decision is less clear-cut, to the GP.

This would utilise the skills of these fellow professionals more fully, minimise inappropriate referral and avoid adding yet more steps to the process and tasks for the GP.

CHARLES CAMPION-SMITH

Cornwall Road Medical Practice, 15  
Cornwall Road, Dorchester, Dorset  
DT1 1RU.

E-mail: [CCampionS@aol.com](mailto:CCampionS@aol.com)

## Reference

1. Menon GJ, Patrick AN. Cataract: a pre-referral protocol. [Letter.] *Br J Gen Pract* 2002; **52**: 411-412.

## Abdominal aortic aneurysm

Clinical examination cannot wholly be relied upon to establish the diagnosis of a ruptured abdominal aortic aneurysm (AAA), especially in the absence of the classical symptoms of presentation. The case report by Lynch,<sup>1</sup> highlights this important principle in dramatic fashion.

A high index of clinical suspicion is therefore necessary, in establishing an early diagnosis, to increase the likelihood of survival from this devastating condition. This observation applies equally to patients presenting to their primary care doctors, as to those in accident and emergency departments.

We report a case, also presenting with right groin pain as the only symptom of a ruptured AAA.

A 78-year-old man attended the accident and emergency department with a four-hour history of sudden onset of right-sided groin pain. He was markedly obese with a small right inguinal hernia. An aneurysm was not

actually palpable. At presentation, the blood pressure was 100/60 and the pulse was recorded as 80 beats per minute. Before a CT scan could be performed, the patient suddenly became hypotensive and peripherally shutdown. He underwent urgent laparotomy and at surgery, a 7 cm ruptured AAA was repaired. The right inguinal hernia was confirmed to be fully reducible with no evidence of strangulation. Unfortunately, the patient died from postoperative complications one week later.

Ruptured AAA can present with isolated symptoms such as testicular and loin pain.<sup>2</sup> The mechanism of pain may be owing to compression of the genitofemoral nerve, as found at post mortem,<sup>1</sup> or as a result of distension of an expanding aneurysm causing excitation of pain fibres, which descend with the sympathetic nerves from the retroperitoneum.<sup>3</sup>

The importance of a thorough and accurate clinical examination is drummed into us from the first days of clinical medicine. Unfortunately, when ruptured AAA present with atypical symptoms, we are not able to fully rely on these fundamental principles. In these situations, a low threshold for laparotomy may be one answer to avoid a catastrophic outcome, but this will inevitably lead to many negative outcomes. Others may feel that the difficulties in diagnosis require the assistance of a helpful radiology department. Ultrasound scans are rapid, non-invasive, and useful in detection of non-ruptured abdominal aortic aneurysm, but are not as sensitive as CT in ruptured abdominal aortic aneurysm.<sup>4</sup> Expedient CT scanning may facilitate appropriate and early surgical interventions. This, coupled with a high index of clinical suspicion,

may provide a higher rate of positive outcome.

IQBAL S SHERGILL

Clinical research fellow in urology,  
Institute of Urology and Nephrology,  
University College London, London  
W1P 7NN.

E-mail: super\_iqi@hotmail.com

D BOSE

Specialist registrar in general surgery,  
North Middlesex University Hospital,  
London N18 1QX.

### References

1. Lynch RM. Ruptured abdominal aortic aneurysm presenting as groin pain. *Br J Gen Pract* 2002; **52**: 320-321.
2. Burke EF, Howard RS, Wear Jb Jr. The abdominal aortic aneurysm and the urologist. *J Urol* 1997; **112**: 123-125.
3. Bergan JJ and Yao TT (eds). *Aneurysms: Diagnosis and Treatment*. New York: Grunne and Stratton, 1982; 205-210.
4. Shih CC, Lai ST, Chang Y. Computed tomography in the determination of surgical emergencies for symptomatic abdominal aortic aneurysm. *Zhonghua Yi Xue Za Zhi (Taipei)* 1998; **61**: 210-215.

### 'Homelessness and Health' conference

I am amazed and disappointed that the *BJGP* should have published such a thoughtless and irrelevant report on the Homelessness and Health Conference in Leeds.

For those of us working in this most challenging of primary care fields it was a superbly organised event. It provided a unique insight as to the social malaise of this country and we were able to share some of the truly inspired initiatives that have been developed over the past decade to support the most vulnerable in society.

Professor Sian Griffiths gave a wonderful overview that helped those of us working in isolation with our marginalised clientele a glimpse of the bigger picture. I applaud the RCGP for its proactive attitude that has been well ahead of Health Authorities, PCOs, and indeed many local authorities.

To those of us who have worked against opposition that has even included the LMCs in the past, the conference provided a vindication of our vision and Dr Iona Heath and Dr Nat Wright are credible role models that we can look to for a continuing lead.

The fact that Simon Tickle could not

get himself organised to get to the conference on time should not be allowed to detract from all the progress that was made by the hard work of the rest of the delegates.

ANNA WILSON

Doctor to Winchester Churches Night Shelter and adviser to Mid Hants PCT on the PMS project for the homeless. 'Tioman', Stratton Road, St Giles Hill, Winchester, Hampshire SO23 0JQ.  
E-mail: dwilson155@aol.com

### Response shift, responsiveness or recall bias?

Elliot *et al*'s paper describing disagreement between patients' prospective and retrospective assessment of pain highlights important issues in the assessment of change.<sup>1</sup> While recall bias was proposed as one explanation for the disagreement, there are two other interpretations which exemplify the difficulties in evaluative research. The first concerns the nature of change in subjective health-related domains. The second relates to current uncertainty about how to assess outcome scale responsiveness.

A model for describing how patients accommodate to illness has been proposed which operates through changes to internal standards, values and conceptualisation of the target construct.<sup>2</sup> The disagreement reported by Elliot *et al* could result from a response shift in patient self-evaluation of the target construct of pain via internal scale recalibration. This is perhaps likely given the essentially subjective nature of pain perception. This explanation is at least as viable as recall bias, which itself assumes stability in the underlying condition.

The responsiveness of the Chronic Pain Grade (CPG) questionnaire was originally assessed by correlation of CPG and SF-36 change scores — a common approach.<sup>3</sup> This doesn't provide a formal responsiveness coefficient and raises problems with identifying a suitable external criterion for comparison with the new outcome measure. Whether a general measure is a suitable gold standard for a condition-specific measure is debatable. How large the correlation should be to conclude that the new scale is responsive is also unclear.

Transition items as used in the study by Elliot *et al* can also be used to calculate responsiveness statistics for outcome measures, although the validity and reliability of such items has been questioned. Data from the present study could therefore be used to further assess scale responsiveness. Disagreement between prospective and retrospective assessments could be interpreted alternatively as a lack of responsiveness of the CPG.

A scale's responsiveness is influenced by its construction. The CPG confounds current state with patient-assessed change — the last two scale items rating change in disability over the previous six months. Paradoxically, patients with maximum disability would show better health on the CPG when re-assessed six months later, compared with patients whose ability has deteriorated over a similar time period but whose absolute level of disability was not as severe.

Competing explanations of recall bias, response shift, responsiveness and even transition item validity counsel caution when interpreting trial results. Further clarification of these phenomena and how they interact should be an important goal for those interested in outcome assessment.

MICHAEL ROBLING

KERENZA HOOD

Department of General Practice,  
University of Wales College of  
Medicine, Llanedeyrn Health Centre,  
Cardiff CF23 9PN.

### References

1. Elliot AM, Smith BH, Hannaford PC, *et al*. Assessing change in chronic pain severity: the chronic pain grade compared with retrospective perceptions. *Br J Gen Pract* 2002; **52**: 269-274.
2. Sprangers MAG, Schwartz CE. Integrating response shift into health-related quality of life research: a theoretical model. *Soc Sci Med* 1999; **48**: 1507-1515.
3. Husted JA, Cook RJ, Farewell VT, Gladman DD. Methods for assessing responsiveness: a critical review and recommendations. *J Clin Epidemiol* 2000; **53**: 459-468.

### GP telephone consultations

Jiwa and colleagues<sup>1</sup> report a fall in demand for face-to-face appointments as a result of introducing telephone triage. They seem to do this on the

basis of a fall in the number of 'extra' appointments filled during the period following the introduction of the service, compared with an historical period that they have assumed to be similar. Some pieces of data that would have enabled the reader to better understand this have been omitted (perhaps for reasons of space). Several factors may influence the numbers of extra appointments (e.g. number of bookable appointments routinely available and the style of doctors<sup>2</sup>). We are not told, for example, if the partnership remained the same during this period. However, we should be provided, in particular, with the following information:

1. The total number of patient contacts (in booked and extra surgeries, preferably nursing and medical, and those managed by telephone) before and after formal triage was introduced; and,
2. Some indication of the appointment length for booked, extra, and telephone consultations.

Anecdotally, surgeries that have introduced telephone triage have seen a rise in the total number of patient contacts. This may not be a bad thing for patients, but adds considerably to the workload of professionals. Using the authors' own figures it appears that almost half of the telephone consultations resulted in an additional consultation that day. Depending on how long the doctors spent on the telephone and how long the average 'extra' appointment took, any time saving is likely to have been minimal or possibly the introduction of triage may even have increased the total time in contact with patients. There may also have been additional follow-up appointments<sup>3</sup>.

Telephone triage provides a useful safety net for patients, but may do so at a cost of increased workload. Despite the authors' enthusiasm they fail to reassure us that this is not the case.

BRIAN MCKINSTRY

Principal of general practice,  
Ashgrove Health Centre, Blackburn,  
West Lothian EH47 7LL.

JEREMY WALKER

Researcher, Department of  
Community Health Sciences,  
University of Edinburgh.

## References

1. Jiwa M, Mathers N, Campbell M. The effect of telephone triage on numbers seeking same-day appointments. *Br J Gen Pract* 2002; **52**: 390-392.
2. Campbell J, Howie JGH. Changes resulting from increasing appointment length: practical and theoretical issues. *Br J Gen Pract* 1992; **42**: 276-278.
3. McKinstry B, Walker J, Campbell C, et al. Telephone consultations to manage requests for same-day appointments: a randomised controlled trial in two practices. *Br J Gen Pract* 2002, **52**: 306-310.

## Chronic fatigue syndrome

I must unpick some of the misconceptions and ill-founded assertions of Stanley *et al.*<sup>1</sup> Many similar errors occur in Michael Fitzpatrick's analysis of the Chief Medical Officer's report so I hope to answer these too in passing.<sup>2</sup>

It saddens me to say that the authors' comments on the Chief Medical Officer's Working Group on chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME) were ill-informed. Had they been party to the discussion they would not have come to the conclusion that they were 'dominated by the sufferers' perspective'. A cursory examination of the ratio of medical to lay people on both the key group and reference group would have shown that the balance was by no means weighted on the side of the patients.

It is also surprising that they allege the report was built without a scientific framework, when it was actually underpinned by a University of York systematic review. This review demonstrated that it is very difficult to be conclusive about many aspects of the illness because of the differing criteria and lack of common standards across research trials. The problems associated with research have been accepted by specialists across all fields, including Professor Simon Wessely, who stated in his editorial on the York Review in the *Journal of American Medicine*, 'much of what exists is poor quality, made worse by the chaos surrounding case definitions, non-standardised outcome measurements, and variations in study duration and follow-up'.

The caution advised by the York

Review is not a refutation of evidence-based medicine — far from it. Indeed, I would like to make the point that it is central to the aims of Action for ME that people with the illness are offered treatments that are properly evidence based. While there remains the absence of universally beneficial treatments, we should also accept, however, that some complementary therapies do seem to help.

Its other findings about the efficacy of management treatments for those who are less severely ill was a point that was accepted (with important caveats) by most of the groups on the report. Equally, almost all of those on the Group (and beyond) accept the need for better research that aims at the development of more effective treatments.

Let me say at this point that Action for ME has recently produced a 'Guide for GPs' following publication of the report, prepared with the advice of our senior medical adviser, Professor Tony Pinching. I would be surprised if the authors disagreed with much of the advice in this guide as it gives clear, cogent guidance on a range of issues, from early diagnosis to treatment programmes and symptom management. I consider that it will be welcomed by GPs who have consistently identified lack of information as the key problem in supporting patients with the illness.

We recognise that there is an important debate to be had among the medical profession about the extent to which problems are over-medicalised. But the manner in which Stanley confuses those people who medicalise their own personal unhappiness with CFS/ME patients in general has done this important debate a disservice.

The fundamental criticism of the report, claim the authors, is that consumerism defined the illness. This indicates that they are not fully informed with what transpired within the Group.

We had no influence in drawing up the terms of the remit nor did we claim to have a definitive model for the patient groups. We were able to support the working group in detailing the experiences of the entire range of people with CFS/ME many of whom simply do not appear in research trials nor, even more sadly, in the doctor's surgery because of the extent of their

disability and consequent isolation. We are in a position to understand the constituency but have seen this as a supporting role, rather than one that awards us special status or allows us in some way to define the illness.

As to the implied point about pressure groups having a self-interest in defining a discrete entity — to put it bluntly we exist to represent people who have the symptoms which are commonly defined as CFS/ME but we take no ideological position other than to say that there is a group of people with such a set of symptoms who to date, have been badly let down by statutory agencies. While we support a properly funded programme of research and equity of service provision, we remain agnostic about models of the illness and simple wish to see those selfsame agencies grapple seriously with some of the common problems associated with the illness — if this results in a better understanding of CFS/ME then all the better.

And this point, in essence, sums up our own amazement at the piece. I had assumed that the purpose of scientific endeavour was to explicate the unknown — Stanley *et al*, by contrast, seem to be lobbying for a kind of clinical quietism: their central tenet seems to be 'we do not know what causes the illness, so let's not try to find out what does'. They are bound to be familiar with the old maxim that absence of evidence does not equate to evidence of absence.

The most damning comment is the quite ludicrous suggestion made by the authors that people with illnesses like ME seek to gain the benefits of victimhood. I have met hundreds of people with ME and I do not remember a single occasion where an individual was seeking to gain from their illness — each and every one has wanted nothing more than to be healthy again.

Let me end by stating that while we are aggrieved by some of the outmoded and short-sighted comments in the piece, we continue, as the UK's largest ME charity, to work with the medical profession in order to enhance our understanding of the illness and to find ways of ensuring that people are able to realise their hopes of a recovery.

CHRIS CLARK

Chief executive, Action for ME.

**References**

1. Stanley I, Salmon P, Peters S. Doctors and social epidemics: the problem of persistent unexplained physical symptoms (including chronic fatigue). *Br J Gen Pract* 2002; **52**: 355-358.
2. Fitzpatrick M. Myalgic encephalomyelitis — the dangers of Cartesian fundamentalism. *Br J Gen Pract* 2002; **52**: 432-433.

**Prescribing costs and patterns: authors' response**

We agree with Wong<sup>1</sup> that a study of the cost effectiveness of an intervention should incorporate both the savings of that intervention and the cost of its implementation. However, the primary aim for our paper<sup>2</sup> was to determine the overall impact of the intervention on the prescribing patterns of the GPs involved, rather than its cost-effectiveness in itself. We reported only the quantitative results of a wider evaluation, although interviews with the GPs concerned revealed that the benefits of the initiative were thought to extend beyond the effects on their prescribing. We shall report these qualitative results in the near future.

Wilcock<sup>3</sup> suggests possible motivating factors for the prescribing changes observed, including a collective ethic of the study practices; again, a discussion of such factors was beyond the scope of our published paper. However, although working together was perceived very positively by some of the study GPs, this was not the case with all of them.

JANE WALKER

Research associate

NIGEL MATHERS

Professor and director,  
Institute of General Practice and  
Primary Care, University of Sheffield,  
Community Sciences Centre,  
Northern General Hospital,  
Herries Road, Sheffield, S5 7AU.

**References**

1. Wong G. Evaluating prescribing interventions. [Letter.] *Br J Gen Pract* 2002; **52**: 412-413.
2. Walker J, Mathers N. The impact of a general practice group intervention on prescribing costs and patterns. *Br J Gen Pract* 2002; **52**: 181-186.
3. Wilcock M. Prescribing costs and patterns. [Letter.] *Br J Gen Pract* 2002; **52**: 500-501.

**Commentary on the EBOR trial report**

We were disappointed to read the commentary that was published within the report of the EBOR trial in the April issue.<sup>1</sup>

While it was true that the commentator reviewed the original manuscript, the editorial advice that we received alongside his review was to 'ignore' various points as these were 'dealt with by the statistician'. To have subsequently commissioned a commentary from the reviewer on this paper could be considered both unhelpful and disingenuous.

As the commentator rightly points out, the design and statistical methods used by the majority of randomised trials in medicine should be appropriate and generally understandable to an informed readership. The statistical report made no reference to inappropriateness in the design of the study; indeed, that report commenced with the comment that: 'The authors should be congratulated on using a randomised controlled trial to investigate the effect of educational outreach....'. The design of EBOR was described in the highly regarded peer reviewed methodological journal '*Controlled Clinical Trials*'.<sup>2</sup> The commentator appears to reject the design but nowhere identifies any weaknesses. Perhaps this is because he cannot understand it.

The statistical report went on to say that, 'the method of analysis used is appropriate...' and made several helpful suggestions on the presentation of the study results, which we were guided by. The analysis of EBOR utilised logistic regression, which is commonly used in this context.

The commentator's main objections to the study appear to be that there was a 'small degree of change and wide confidence intervals'. Overall there was a modest but statistically significant effect from outreach, and 5.2% more patients were managed within guidelines recommendations attributable to outreach (95% CI = 1.7% to 8.7%). Despite the large size of the study the confidence intervals were relatively wide because of the need to take into account the clustering effect of delivering the interventions at the practice level. Through one

of a small number of pre-specified factors examined for their potential predictive value, it was established that the effect was concentrated in smaller practices (those with one or two members; effect in small practices 13.5% [95% CI = 6% to 20.9%]) compared with effect in larger practice (1.4% [95% CI = -2.4% to 5.3%], *P*-value for interaction <0.001). The results may challenge the commentator's prior beliefs since he recommends a broad role for pharmacists without citing any evidence except his own experience — a view unsupported by the EBOR trial in large practices.

Overall we are not opposed to the practice of publishing commentaries alongside articles. However, if these are to fulfil a useful function we contend that they should be written by a commentator who understands the issues, rather than one who does not.

NICK FREEMANTLE  
IRWIN NAZARETH  
JOHN WOOD  
ANDY HAINES  
MARTIN ECCLES

Department of Primary Care and General Practice, University of Birmingham.

### References

1. Freemantle N, Nazareth I, Eccles M, *et al.* A randomised trial of the effect of educational outreach by community pharmacists on prescribing in UK General Practice. *Br J Gen Pract*, in press.
2. Freemantle N, Eccles M, Wood J, *et al.* A randomised trial of Evidence Based OutReach (EBOR): rationale and design. *Control Clin Trials*, 1999; 20: 479-492.

### Screening for atrial fibrillation

Morgan and Mant,<sup>1</sup> in their paper on screening for atrial fibrillation, report that they were able to assess 73% of the group randomised to systematic screening by invitation but only 29% of the group randomised to opportunistic screening. The low uptake for opportunistic screening may be because they didn't allow enough time for the study.

The Cumbria Practice Research Group was able to assess 85% of the study population by opportunistic screening for irregular pulse.<sup>2</sup>

There were differences in methodology. Morgan and Mant flagged paper

medical records and used computer prompts. We used only paper medical records (but would now also use computer prompts if we were repeating the study). Their method should have led to a higher uptake. More importantly, our study period was 12 months compared with their six months. It seems logical to allow more time for opportunistic screening than for screening by invitation.

We found that placing a pre-printed Post-it note on the active continuation sheet of the medical record was an easy and effective way of prompting the doctor or nurse to assess the pulse for irregularity. Once the patient had been assessed the doctor or nurse completed the Post-it note and placed it on the front of the record so that clerical staff could remove and save it before filing the record.

JIM COX

Caldbeck, Cumbria.

ELERI RODERICK

Church Cottage, Cusop, Hay-on-Wye, Hereford, HR3 5RF.

E-mail: Eleri@rodericke.freeserve.c.

### References

1. Morgan S, Mant D. Randomised trial of two approaches to screening for atrial fibrillation in UK general practice. *Br J Gen Pract* 2002; 52: 373-380.
2. Roderick E, Cox J. Non-valvular atrial fibrillation. *Br J Gen Pract* 1997; 47: 660-661.

### Intuition, creativity, dialogue, tacit knowledge and ... evidence?

Professor Greenhalgh's marriage of evidence-based medicine (EBM) and clinical intuition is most welcome.<sup>1</sup> Polanyi<sup>2</sup> memorably said that 'we know more than we can say'. Intuition may be one of the processes where tacit knowledge in the form of cross-referenced, clinical scripts can be swiftly, accurately, and flexibly accessed.<sup>3</sup> Such scripts may represent the stored products of clinical experience that can be continuously improved by reflective review. Case presentations, Socratic ward rounds and 'battle reports' may be some ways in which they are acquired by the novice.

Intuition in the clinical setting can be intensely creative and aesthetically sat-

isfying but it must be fallible. How is it fallible and on which occasions does it fail? EBM is going to have a diminishing shelf life as the rate of change of new knowledge continues to decrease, and what is evidence, precisely? Each partner would have his or her respective virtues and flaws. Is clinical intuition available to everyone or is there a gender bias? Does it require an innate creativity, possibly a 'sensitivity to similarity',<sup>4</sup> to be effective? How do you know when it is present and being used as well as it can be?

Wider acknowledgement of the role of tacit knowledge, intuition, creativity and the dialogues by which these processes are acquired and maintained, is vital. Self-referenced, versatile and intuitive learners will only emerge from structured training programmes if the recipes are correct. The absence of a significant evidence base in obstetrics and gynaecology means it may be particularly important to women and their carers. If evidence-based Balint groups emerge then perhaps obstetricians and gynaecologists could be invited?

MARTIN QUINN

Hinchingbrooke Hospital, Huntingdon.

### References

1. Greenhalgh T. Intuition and evidence — uneasy bedfellows? *Br J Gen Pract* 2002; 52: 395-400.
2. Polanyi M. *The tacit dimension*. New York: Garden City, 1966.
3. Abernathy CM, Hamm RM. *Surgical intuition: what it is and how to get it*. Philadelphia, PA: Hanley & Belfus, 1995.
4. Bohm D. *On creativity*. London: Routledge, 1994.