Referral letters are inadequate

EDITOR,—Paul Little and colleagues' finding that when patients present with acute back pain most general practitioners do not routinely examine them for muscle weakness and sensation¹ agrees with a recent audit that we have performed to assess the contents of referral letters sent to a back clinic. We were concerned about the rising number of referrals and the fact that the accompanying referral letter was often inadequate. An audit of 153 consecutive letters showed that age was given in 44 letters and occupation in 49. Twenty one commented on the duration of symptoms and 29 on the onset of the current problem. Only 11 letters mentioned bowel or bladder function. The outcome of any previous treatment was reported in only 29 cases. Findings on examination were given in 86 letters, but any special tests were mentioned in only 40.

It is disappointing to learn from Little and colleagues' survey that existing guidelines on the management of back pain² do not seem to be acted on. For those surgeons who are receiving an increasing volume of referrals for back pain the referral letter is of paramount importance: it is our only clue about the urgency with which an appointment must be offered. If no comment is made about any clinical findings, deciding this is not easy. We plead for improved letters.

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Research on which to base guidelines is possible in primary care

EDITOR,—Paul Little and colleagues' study shows the difficulties encountered in applying evidence of effectiveness in general practice.¹ The authors question the applicability to primary care of evidence derived from another setting. What struck me, however, was that one third of the respondents rated their satisfaction with their management of back pain as ≤ 4 out of 10 (I had thought that it might be worse than that).

This raises a few questions. Firstly, as dissatisfaction in managing a problem may reflect a self identified lack of knowledge, I would be interested to know if there was any relation between respondents' satisfaction with their management of back pain and other variables, such as level of examination, giving advice on exercise, and missing danger signs. Similarly, a perceived inability to influence the course of a disease or condition is likely to lead a doctor to have feelings of therapeutic inadequacy. This may be reinforced by the response of the patient. In this study was there any relation between satisfaction and respondents' provision of manipulation (for which some evidence of efficacy exists) or acupuncture (for which less evidence exists)?

The authors conclude that there is a lack of research grounded in primary care on which to base guidelines on the management of back pain in primary care. This cry is often repeated whenever the issue of guidelines is raised. Clinical effectiveness is in the ascendancy, and it should increasingly be incorporated into the audit process. If we couple this with the new primary care led NHS, with general practitioners leading the

commissioning of effective local services, then the opportunities to ensure that appropriate resources are directed to research based in primary care should be neither underestimated nor missed. But it is an activity that has to be both wanted and asked for, at national and local levels.

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Routine feedback to GPs who request microbiological tests is effective

EDITOR,—Ron A G Winkens and colleagues report a scheme in Maastricht whereby general practitioners are given feedback about tests that they request.¹ This provides a good solution to the increasing demands on haematology and chemical pathology laboratories that occur as a result of increasing numbers of requests for tests from the community. The authors give little information, however, on requests for bacteriological, serological, and virological tests. The impact of strategies to manage the demand for tests is poorly studied in microbiology compared with haematology and chemical pathology.²⁻⁴

Since January 1994 we have been studying the effect of our laboratory returning information on microbiological tests to the general practitioners who requested them. The information provided has increased in complexity, from simple data on numbers of specimens to activity corrected for list size and, finally, the yield of positive cultures for each general practitioner, with comparative data ranking individuals and practices. Unlike the authors in Maastricht, we do not comment on the appropriateness of the requests. One third of the general practitioners did not receive any feedback and served as a control group. Requests from the control group were indexed to the number of patients in the feedback group (table 1). When a test fit straight line was fitted to the data the slope was -38.21 (95% confidence interval -77.94 to 1.51 ; $r^2 = 0.8955$) in the group receiving feedback and 89.17 (34.89 to 143.44 ; $r^2 = 0.961$) in the control group. In the control group the number of specimens received by the laboratory increased by 13.1% over two years while in the group receiving feedback it fell by 4.6%.

The information provided has been generally well received by the general practitioners, several of whom have made suggestions about how the feedback exercise could be improved. We believe that our data are the first generated from British general practitioners requesting microbiological

tests and that they confirm and expand the Dutch experience in haematology and chemical pathology.

Feeding back information about requests for laboratory tests may provide a valid, non-threatening way of managing demand for microbiology laboratory services. It can help to encourage partnership between general practitioners and microbiologists by providing data for rational detailed discussion of requesting patterns. The basis of this partnership should be to ensure the most appropriate use of laboratory services. Those motivated purely by financial considerations may well be disappointed as reduced use of laboratory services is likely to provide smaller than expected reductions in costs.⁵

This project is supported by the South and West research and development directorate.

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Research priorities in complementary medicine

EDITOR,—Prioritising research in a climate of limited resources has become an important issue; complementary medicine is no exception in this respect.¹ Yet it is sometimes claimed that complementary medicine is so fundamentally different, in its operation if not in its goals, from mainstream medicine that its investigation requires a different research agenda.²

In an attempt to determine which priorities are most important to people practising and researching in complementary medicine, participants (from 11 countries) due to attend a recent international scientific meeting on complementary medicine (2nd annual symposium

Table 1—Number of specimens received for microbiological testing, January 1994 to December 1995

	No of specimens		% Change	
	Group given feedback	Control group*	Group given feedback	Control group
Jan-Jun 1994	15 596	12 806		
Jul-Dec 1994	15 474	13 662	-0.78	6.68
Jan-Jun 1995	15 329	13 978	-0.94	2.31
Jul-Dec 1995	14 880	14 484	-2.93	3.62
Overall change			-4.59	13.10

*Indexed to number of patients in feedback group.

on complementary healthcare, University of Exeter) were sent a questionnaire by post and were asked to return it before the meeting. It consisted of 22 research questions, in strict alphabetical order, applicable to complementary medicine; participants were required to choose which they considered to be most important and to rank them accordingly. Of the 85 questionnaires sent out, 50 were returned by the cut off date. An overall weighted score was determined for each question, and two questions were without doubt the top priorities: how can we improve research methodologies? and, is a given therapy more effective than placebo, sham, or gold standard treatment? Clearly, for this international audience, the efficacy of therapy and how it can be determined had the greatest priority. The remaining three most highly rated questions (is a given therapy safe, are complementary therapists medically competent, and are diagnostic methods used validly in complementary medicine) illustrate the concern for patient safety.

There was some discussion during the meeting that questions about "outcome studies" had not featured in the original questionnaire. Nevertheless, the clear preference of the group for the rigorous evaluation of treatments and their safety implies that mainstream and complementary research should have a similar focus, bearing in mind that existing methodologies may need to be adapted and refined for optimum use in complementary medicine.

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Jumping through hoops to buy equipment

EDITOR,—One of the penalties we clinicians now have to pay as members of the European Community is totally unnecessary bureaucracy to obtain new equipment. As if resources within the NHS for expensive medical equipment are not hard enough to come by, we now have the added burden of considerable delay in making a purchase.

To obtain equipment costing over £108 667, the purchaser must advertise in the *Official Journal of the European Communities* for a minimum of 52 days before starting to assess bids for new equipment. The echocardiograph in my hospital is broken and repair is impractical. Because this new bureaucracy is the only method of obtaining a new machine, we will almost certainly be without one for three months. This purchasing procedure can have a knock on effect in any trust that needs expensive equipment to run a safe service.

Purchases must now be made through NHS Supplies, which requires a fee for procuring any equipment that needs to be advertised in the *Official Journal*. The initial fee to cover the tendering and procurement work is over £1000, further stretching funds and shifting money away from patient care.

There is something wrong with a system that delays our ability to purchase essential medical equipment. The intervention of Brussels and the bureaucrats is something that we in the NHS, together with the BMA, should be opposing.

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British health insurers fail to learn lessons from the US

EDITOR,—Colleagues should be aware of a feature of many lower cost medical insurance plans. I recently saw a patient for neurological symptoms, referred by her general practitioner, with severe headaches and a blood pressure of 180/130. In association with a cardiologist, I arranged appropriate outpatient investigations. When the patient submitted the accounts to the insurers she was informed that, in regard to outpatient consultations and subsequent investigations, "in accordance with the rules and benefits of your plan, we are only able to provide benefit for such treatment if it relates directly to inpatient or day care treatment, or a surgical procedure as an outpatient, and is received just before that treatment, or within sixty days afterwards." Her insurer has kindly sent me a copy of the scheme under which the patient is insured, and the information the patient received is indeed cited in the policy. The insurer has informed me that the company endeavours to make the nature of the plans that patients buy entirely clear. My concern is not with any misunderstanding on the patient's part but with the potentially distorting effect of such limited plans on the provision of health services.

It seems invidious that consultative advice to patients should be seen as less worthy of financial support than inpatient treatment or "procedures." Furthermore, a physician or surgeon might, in partnership with the patient, advise a related but inappropriate admission or surgical procedure solely to aid the patient in recovering the costs of the outpatient consultations. Certainly some patients have asked me to admit them inappropriately for neurological investigation so they can claim them on their health insurance, and related experience in the United States does not suggest that every physician or surgeon refuses on every occasion. I believe that marketing such insurance plans will lead to more inappropriate admissions and procedures and drive up the costs of private health insurance. Such plans also leave patients exposed to expenses which, however clearly the restrictions on benefits are described, leave them embittered that their expectations of purchased health cover have not been fulfilled.

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Orphanages in China require more funding

EDITOR,—Peter Kandela's interview with Dr Zhang Shuyun is yet another contribution to the one sided picture we have been given of the situation in Chinese orphanages.¹ Although the interview, which describes previous conditions in one orphanage, is not in itself contentious, it relates to a report by Human Rights Watch/Asia that made sweeping generalisations about conditions in Chinese orphanages while failing to substantiate many of the claims.² The most worrying allegations in the report are, firstly, that a systematic policy of "summary resolution," or deliberately allowing children to die, is widespread in orphanages in China; and, secondly, that orphanages are well funded and orphanage workers well paid, which leads to the report's conclusion that the problems are not related to underfunding.

I have spoken on this subject to a number of people who have worked in orphanages for Chinese and foreign non-government organisations. None has been aware of a policy of summary resolution or anything approaching it. There are many problems, but all agree that these relate to chronic underfunding of the social welfare system. This is so obvious to those at the

sharp end that how it can have been presented otherwise is hard to understand. (Underfunding is also a serious problem in the education and health sectors, where survival in the new market economy now depends on fees for service.) Orphanages, being non-profit institutions, depend entirely on government grants. This means that staff do not get any income from bonuses, which form the bulk of the income of most workers; this fact is misunderstood by the writers of the report. The result is that orphanage workers are among the lowest paid government workers. This, together with poor working conditions, results in low morale. This in turn results in neglect in some cases, which, of course, cannot be condoned but occurs in poorly funded institutions the world over.

Improving the work of orphanages requires more funding, better management, and greater accountability of those involved. The report comes at time when many local initiatives (for example, fostering, adoption, and rehabilitation schemes) are gaining momentum in China, and many examples of excellent practice now exist.³ The fact that these efforts are ignored reduces the morale of orphanage staff further. This will make it harder for non-government organisations to bring about further improvements.

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Albanian orphans

EDITOR,—Sir Jonathan Boyce, a director of health studies with the United Kingdom's Audit Commission, has been extremely critical of Albanian mental hospitals and orphanages.¹ His comments are particularly unfair since they ignore conditions in some British psychiatric institutions which are as bad as, if not worse than, anything in Albania.^{2,3} Boyce joins many other British health professionals who have been on foreign tours and have returned to publish undiplomatic articles which can only be hurtful to their previous hosts.

Boyce's account is the most offensive to date with his suggestions that the Albanian staff are lazy, that they play with children in their care only because of the foreign visitors' example, and that "perhaps the volunteers' greatest contribution is their demonstration of compassion: showing that they care about the clients. Some of it undoubtedly rubs off."

The Albanian care assistants, nurses, and doctors will no doubt persevere with their difficult work under conditions of serious economic hardship. If they ever see Boyce again I hope they can explain to him the difference between compassion and wishful thinking. Perhaps the Audit Commission's publications would then contain more realistic approaches to improving the community care of seriously mentally ill people in Britain.⁴

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