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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- 1 Little P, Smith L, Cantrell T, Chapman J, Langridge J, Pickering R. General practitioners' management of acute back pain: a survey of reported practice compared with clinical guidelines. *BMJ* 1996;312:485-8. (24 February.)
- 2 Clinical Standards Advisory Group. *Management guidelines for back pain*. London: HMSO, 1994.

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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- 1 Little P, Smith L, Cantrell T, Langridge J, Chapman J, Pickering R. General practitioners' management of acute back pain: a survey of reported practice compared with clinical guidelines. *BMJ* 1996;312:485-8. (24 February.)

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

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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.