Table 1—*Result of Medline search for "case-control studies," "questionnaires," and "family practice" 1992-6*

MeSH heading	No of citations
1 Case-control studies	9172
2 Questionnaires	14 786
3 Family practice	6863
1+3	21
2+3	548

questionnaire studies to case-control studies was 1.6:1, whereas for family practice the ratio was 26:1.

The time has come to redress the balance and move on from placing too much emphasis on questionnaire surveys as a quantitative method of research in general practice.

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1 McAvoy BR, Kaner EFS. General practice postal surveys: a questionnaire too far? *BMJ* 1996;313:732-4. [With commentaries by S Lydeard and by M P Springer and H W J van Marwijk.] (21 September.)
2 Black N. Why we need observational studies to evaluate the effectiveness of health care. *BMJ* 1996;312:1215-8. (11 May.)
3 Hennekens CH, Buring JE. *Epidemiology in medicine*. Boston: Little, Brown, 1987.

Surveys demand too much time

EDITOR,—I suppose that I identify myself as one of the general practitioners who do not respond to postal surveys as defined by Brian R McAvoy and Eileen F S Kaner—older, more experienced, and possibly under stress.[1] But there is another reason for the failure to complete and return questionnaires.

Over the past few months I have been collecting (not returning) questionnaires and now have a total of 19. Eight of these are "national" surveys, nine are from my family health services authority or health authority, and the remaining two I am unable to classify. One offered to advise me of the results; five had "threatening" deadlines (this must be completed and returned by ...). The only incentive to completion was the chance to win a weekend in Amsterdam. Given that each questionnaire would take some 10-15 minutes to complete, filling them all in would take 3-4 hours of my time. I recollect that in my first 10 years in general practice I completed perhaps one survey a year.

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1 McAvoy BR, Kaner EFS. General practice postal surveys: a questionnaire too far? *BMJ* 1996;313:732-4. [With commentaries by S Lydeard and by M P Springer and H W J van Marwijk.] (21 September.)

Scotland's new chief medical officer welcomes reforms of training

EDITOR,—A recent item in Medicopolitical Digest implied that I (now the chief medical officer in Scotland) was critical of the current reform of postgraduate training.[1] This is not the case. I welcome the reforms, and during my chairmanship of the Scottish Council for Postgraduate Medical and Dental Education I helped to alter the funding and delivery of postgraduate training. My purpose at the BMA's clinical meeting in Istanbul was to highlight several unresolved issues that could adversely affect implementation of the reforms and compromise moves towards a health service delivered by consultants.

I did indeed emphasise the problems posed by a reduction in the hours of training, and, while I subscribe totally to the view that specialist training can be condensed if training programmes are structured, we must be careful to ensure that the consultants who emerge are sufficiently experienced to fulfil the demands expected of them. Junior doctors in some acute specialties are aware that a reduction in working hours may adversely affect their training if carried too far, and there have been heartening moves to define and monitor the quality of training offered to them. I strongly oppose any return to the prolonged unstructured apprenticeships of the past, but I suspect that some doctors pursuing careers in highly specialised areas may elect to gain additional experience after completing conventional specialist training.

I am not enthusiastic about the suggestion that consultants produced by the new training programmes will be identified as junior consultants, and I suspect that most of them would find this offensive. We all, however, need to accrete experience throughout our professional life, and many newly appointed consultants will find the help of senior colleagues particularly welcome at the start of their consultant career. In surgery there is a growing acceptance that the nature of a consultant's working week may change as his or her career progresses, and this could be beneficial as far as support for new colleagues and an increased role in teaching are concerned.

It would be tragic if the potential benefits of the reforms of training were lost because of failure to make the necessary adjustments elsewhere in the system. The successful development of all aspects of our NHS will depend on the continued commitment of a motivated and sufficiently numerous consultant workforce. Postgraduate training is no exception.

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1 Beecham L. New Scottish CMO criticises training reforms. *BMJ* 1996;313:947. (12 October.)

Adverse events associated with mefloquine

Study in returned travellers confirms authors' findings

EDITOR,—The excess of disabling neuropsychiatric side effects of mefloquine reported by P J Barrett and colleagues has attracted attention.[1] Focus on disabling reactions has detracted from milder disturbances, which may be sufficiently common to reduce compliance and increase the risk of malaria.[2] We conducted a questionnaire based survey among recently returned travellers to assess the impact of adverse reactions on compliance.

Altogether 347 questionnaires were returned (response rate 60.5%), 255 of which were from respondents who had been born in malaria free areas, were based in Britain, and were attending our hospital for reasons not involving malaria. The median age of these 255 patients was 30.5 years and their median length of travel 3.2 months. One hundred and thirteen respondents had taken mefloquine, 81 had taken chloroquine plus proguanil, and 61 had used alternative regimens or no prophylaxis. The rates of reported side effects were high: 80 (71%) respondents who had taken mefloquine and 52 (64%) who had taken chloroquine plus proguanil reported one or more side effects. Depression and anxiety were more common in those who had taken mefloquine, with 23 (20%) of this group and 8 (10%) of those who had taken chloroquine plus proguanil reporting symptoms ($\chi^2 = 3.86$, $P<0.05$). Only 16 (14%) of those who had taken mefloquine and 11 (14%) of those who had taken chloroquine plus proguanil, however, reported having stopped their prophylaxis because of side effects.

Forty five (30%) travellers to Africa and eight (8%) travellers to other destinations had been treated for symptoms of malaria at least once. Among the travellers to Africa 24 (26%) of the 94 who had taken mefloquine and 17 (40%) of the 43 who had taken chloroquine plus proguanil had been treated for symptoms of malaria, and seven had stopped using prophylaxis as a result. The drugs used for treatment varied and in some instances were potentially ineffective or dangerous.

Although people attending hospital are not representative of travellers as a whole, our survey supports Barrett and colleagues' findings of an increased frequency of neuropsychiatric side effects in people taking mefloquine. Side effects severe enough to necessitate discontinuation of prophylaxis were, however, similar in people taking mefloquine and those taking chloroquine plus proguanil. A high proportion of the cohort had received treatment for symptoms of malaria while abroad. Travellers need advice on drugs' side effects before they travel and should ideally be provided with emergency treatment for use if malaria is diagnosed abroad. They should be warned of the risk of breakthrough infections and advised not to stop their prophylaxis without seeking medical advice.

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1 Barrett PJ, Emmins PD, Clarke PD, Bradley DJ. Comparison of adverse events associated with use of mefloquine and combination of chloroquine and proguanil as antimalarial prophylaxis: postal and telephone survey of travellers. *BMJ* 1996;313:525-8. (31 August.)
2 Cook GC. Malaria prophylaxis. *BMJ* 1995;311:190-1.

Women may be more susceptible to adverse events

EDITOR,—The methodology that P J Barrett and colleagues used in their study comparing adverse events associated with mefloquine with those associated with chloroquine plus proguanil for antimalarial prophylaxis[1] is similar to that used in a study that Kass and I carried out.[2] We, however, compared mefloquine with doxycycline, which is widely used by Australians and North Americans as the alternative to mefloquine for travellers to chloroquine resistant areas.[3] Our subjects were enrolled in the study prospectively, at the time that their drug was chosen, and received a postal questionnaire after returning from their trip. It is reassuring that, with respect to the tolerability of mefloquine, our results were so similar to those of Barrett and colleagues (table 1)

Barrett and colleagues detail the cases of 10 people who used mefloquine and suffered disabling neuropsychiatric adverse events. They do not, however, comment in their discussion on the fact that eight of these subjects were women. This would represent a rate of disabling neuropsychiatric events in women taking mefloquine of 8/698 (1.1%). In our study all disabling adverse events occurred in women taking mefloquine, with a rate of major neuropsychiatric events of 3/171 (1.8%). Two of the three women