aging grief reactions among patients. To this end the protocol has much to commend it. General practitioners will find many of the suggestions appealing and may wish to incorporate them into their own guidelines.

Before we adopt such a policy unreservedly, however, it is important to consider the dangers of overmedicalizing grief. Grief can be considered a normal part of ageing.[1] The more the medical profession become involved in bereavement, the more it takes on the connotations of a disease.[2] The resulting medical responsibility could have sociolegal consequences. It may, for example, weaken patients' existing supportive social constructs. This could have implications beyond the immediate bereavement, as society learns a new model for coping. On an individual level, it could also limit the person's emotional growth that can come from grief.[3]

Given these concerns, it is imperative that any future protocol has clearly defined benefits. This is achievable, given the evidence for bereavement counselling, although we must remember that this research has been based in non-primary care settings.[4] Also, in order to facilitate successful counselling, there is an advantage in planning care according to a risk assessment. This can be performed by applying forms used in hospices.[5] There may be some benefit from delaying this assessment until the rituals of death are complete, when the bereaved patient's true vulnerability may be more apparent.

An additional concern relates to applying a uniform approach to what is a highly individualized, complex psychological phenomenon. A bereavement protocol has to respect this by being versatile. The protocol suggested by Charlton and Dolman allows the general practitioner an individually tailored response to a bereaved person. However, it should also ensure that it fully complements existing professional and social care. A combination of a risk assessment and an awareness of all the follow-up options will facilitate appropriate intervention. Such an approach perhaps needs to be incorporated into the protocol. This desire for versatility needs to be considered for any written material used. Care needs to be taken in its preparation and piloting, as this information must be presented in a form helpful to the general public.

Grief has considerable health implications that require the attention of primary care. However, any approach to the problem of such implications has to have clear benefits and be sensitive to the social context of bereavement. In order to answer these anxieties there is a need to expand the limited research into bereavement and bereavement support in primary care, particularly in the evaluation of any proposed innovations.

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Sir,

The paper by Charlton and Dolman discussing the use of a bereavement protocol in primary care (August *Journal,* p.427) appears to omit one important date of contact between a general practitioner and his or her bereaved patient. This is between six and eight weeks after the event, when the relatives, counsellors and others have gone their way and the bereaved person is having to face life as it really is, alone. This date has the added merit of being one by which psychotic depression, as opposed to justifiable misery, is relatively obvious, relatively common, but entirely treatable.

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GP–patient social and sexual contact

Sir,

I was interested in the article by Coverdale and colleagues on social and sexual contact between general practitioners and patients (May *Journal,* p.245) because of its importance and because I was one of the doctors who replied to the questionnaire. Two aspects of the study are open to criticism.

No distinction was made between general practitioners working in rural and urban areas, between single and married general practitioners and between single and married patients. There is a vast difference between a single general practitioner working in a rural area who has to suture a cut finger of a young woman patient whom he then meets socially in the community (they are attracted and marry or become lovers); and a married general practitioner working in a city who seduces a patient who has attended him for counselling about an unsatisfactory marriage. More useful information could have been gained from the study if general practitioners had been asked to judge perhaps six such scenarios.

The other criticism is that there was no way of distinguishing how the general practitioner respondents in the study had learned about sexual contacts between other general practitioners and patients and whether reported cases were public knowledge. The three cases known to me were general practitioners whom I knew personally and whose names had been published in the *New Zealand Medical Journal.*

I hope that this important study is not taken as a baseline against which to measure any future changes but that it is considered as a pilot study from which comes further work on what many would see as one of the most serious breaches of trust between doctors and their patients.

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Complementary medicine

Sir,

I would like to comment on the letter from Ernst and colleagues (September *Journal,* p.506) which gave a definition of complementary medicine. Many doctors besides me must have long been puzzled by the need for such a definition. A definition of complementary medicine would be unnecessary if the discipline of medicine itself were properly defined as 'the study of human ailments and of the methods employed for their prevention and treatment'. All ailments, preventive strategies, diagnostic procedures and treatments must then be subject to the scrutiny of the one inclusive discipline. All effective preventive strategies, diagnostic procedures and treatments are subjects of medicine and