clinical efficacy and systemic availability are all measured in the same study. It is inappropriate to infer clinical differences extrapolated from studies using different methodologies, sometimes with patients, and at other times, with healthy volunteers. These points have been aired and discussed in recent correspondence.[3,4] Any device which deposits more medication in the lung may or may not produce a greater clinical effect depending on the dose response curve of the medication in that patient at that time. However, it is unquestionable that such a device will increase the systemic bio-availability of the deposited medication.

Finally, I am intrigued by the authors' suggestion that fluticasone propionate is a more potent inhaled corticosteroid but that this does not translate into increased efficacy in doses greater than 1 mg day^{-1}. It is particularly when high doses of inhaled corticosteroids are required that chest physicians and respiratory paediatricians have extensively used fluticasone propionate and found it to be a clinical improvement compared with previously availably inhaled corticosteroids. Could I suggest that, although it is possible to fool some of the people some of the time, ultimately the proof of the pudding is in the eating — or even possible in the inhaling?

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MRCGP to MRNZGP

Sir,

Upon completion of my VTS last August in London, and having become a MRCGP, I decided to visit New Zealand to see what their general practice had to offer. Fresh with college ideas and input, I found it interesting to compare the New Zealand training schemes and college entry requirements with those in the UK.

New Zealand has no formal VTS like those in the UK that link the GP registrar year with hospital jobs. To work in general practice, you must have completed 2 years as a house-officer. This usually includes A&E, paediatrics and O&G posts. Vocational training (GPTP) run by the RNZCGP consists of a 10-month attachment in general practice as a GP registrar. This is often split between two or three practices, where you work under a supervisor who is a MRNZCGP. The training programme during these attachments is similar to that in the UK. Many GP registrars have also done SHO posts in paediatrics and O&G and may have taken diploma exams in these specialities.

Following completion of the GP registrar year, registrars sit the Primex exam.

This exam includes MCQ, slide quiz, critical appraisal paper, and three role-play consultations assessing communication and diagnostic skills. It is very similar to the MRCGP exam. General practitioners not enrolled on a GP registrar training scheme can also sit this Primex exam, either with no formal preparation or by attending a seminar programme. Completing a GPTP and passing the Primex exam gains you access to the college accreditation process to become a MRNZCGP. Accreditation involves a professional report and plan, CME programmnes, a consultation/patient satisfaction survey, video consultation review, and finally, a practice visit. This can be completed over 2 years if working full-time in general practice. Currently, the MRCGP gains you access to the 2-year accreditation process. Accreditation is over a longer period if working part-time or no GPTP has been completed.

Following accreditation, there is reaccreditation, a 5-year cycle that must be undertaken to retain the privileges of College membership.

The future is uncertain. Some would like to see college membership a requirement to practice, something that is also being discussed in the UK. Having seen first-hand the RCGP and RNZCGP approaches to training, I can see some benefits in both. Whether you approve or disapprove of either process, what is clear is that th two colleges have set themselves the same goals, i.e. to improve the standing of GPs and improve the quality of care offered to our patients in general practice.

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Corticosteroids in the management of croup

Sir,

A recent Editorial in the *BMJ* suggested that, if GPs treated mild to moderate croup with nebulized Budesonide, rather than steam, fewer children might need hospital admission.[1] The evidence is derived from hospital studies, but I was prompted to analyse my practice's emergency admissions with croup during the last 5 years.

Our population of 13 000 closely matches the national average for age distribution, with 6% under 5 years old. All the on-call duties have been covered by the seven partners. The computerized morbidity index records 11 children (nine boys and two girls) admitted a total of 14 times with a hospital discharge diagnosis of croup. All except one were aged less than 2 years, 9 months. The months of admission are shown in Table 1.

Table 1. Croup admissions by month.

	Month											
	J	F	M	A	M	J	J	A	S	O	N	D
Number of admissions	2	2		1	2	1			1	1	3	1

Ten out of 11 sets of notes were available for review. None of the children were treated with Budesonide prior to admission, although four had been given steam and four received bronchodilators. In hospital, four received nebulized Budesonide and rapid recovery was recorded in each case. The others received steam, bronchodilators or antibiotics. Nine of out ten had many other consultations or admissions with respiratory infections or asthma. The most striking feature is the overlap with asthma in the signs, treatment and subsequent diagnosis, even if the classical barking cough was present initially.

In summary, the small number admitted were mostly boys aged under 3 years, with a frequent history of respiratory problems. Important non-therapeutic factors influenced admission in three children: (1) Down's syndrome; (2) cleft palate and learning difficulties; and (3) family anxiety because of a brother's Sudden Infant Death. Excluding these three, up to 11 out of 14 admissions could perhaps have been prevented if better home treatment was available. Nebulized budesonide certainly

seems to deserve a trial.

One difficulty in promoting a controlled community study is that croup is usually worse at night yet, as Doull states, 'it is essential that the child is reassessed two to four hours after treatment'.[1] This may not be so difficult for on-call cooperatives or deputizing services, but their doctors might be less reliable in the recruitment of patients. The GP on call for his own patients may be more motivated about the trial, but might choose to admit a child to hospital in order to protect his own sleep.

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Referrals between GPs and complementary practitioners

Sir,

In Britain, as in most countries, general practitioners (GPs) and non-medically trained complementary practitioners (NMTCPs) of various guises work in almost entirely separate settings and systems.[1] Little is known about the level of cooperation between the two. Therefore, we have assessed the referral rates between GPs and NMTCPs in a large sample of 'arthritis' sufferers. These were individuals responding to an article in a British *Woman* magazine (falsely) reporting that our unit was recruiting volunteers for a trial of complementary therapy for 'arthritis'. Some 3384 people wrote to us on this occasion and all were sent a questionnaire, of which 1020 were received back. Three questions related to the interactions of GPs and NMTCPs:

1. Did your GP know that you were receiving complementary therapy?
2. Has your GP ever recommended you for complementary therapy?
3. Has your complementary practitioner ever recommended you to a doctor?

The first question was answered with YES by 25.4% and with NO by 23.2% (the rest abstained from answering it). Evaluating only those individuals who were using *both* types of approaches (n=301), 56.1% answered with YES and 34.9% with NO. Only 9.2% of the respondents had ever been recommended by their GP for complementary therapy. Looking at the sub-sample with experience in mainstream *and* complementary medicine, this figure was 20.9%. When asked whether NMTCPs ever referred to GPs, only 6.5 said YES. Again evaluating the sub-sample with dual experience, the figure was increased to 15.3%.

These data are disappointing and disquieting. They imply a level of non-cooperation that surely must be counter-productive. Data from the US suggest GP referral rates of between 23% for acupuncture and 0% for herbalism.[2] To the best of our knowledge, no information exists on the referral frequency of NMTCPs to GPs. As NMTCPs are embarking on their way to mandatory professional standards, one would hope that they find ways of sharing essential patient information with GPs. Conversely, as NMTCPs become more professional, GPs should start cooperating. It seems that this is not so much a question of one camp expressing sympathy for the other, but a question of putting the interests of the patient first.

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Assistants in general practice

Sir,

In view of the fact that it is now widely acknowledged in the profession that we have a recruitment crisis in general practice,[1] it seems to me that the profession as a whole would be well advised to look at the plight of assistants in geneal practice. In a recent seminar run by the Birmingham faculty of the RCGP to explore this issue, it emerged that GP assistants felt that they were a sidelined group who were isolated and had low status in their practices and in the NHS. In addition to this, there were problems with them getting involved with the NHS pension scheme and they had no access to some of the benefits that principals enjoy, such as the postgraduate education allowance. To name just three points out of many:

1. There was a disincentive to study as the assitant not only lost the money that would have been paid for working the missed session, but also had to pay for the course itself.
2. It emerged that those vocationally trained doctors working as assistants in general practice face the prospect of having to do their vocational training again if they do not become principals within 10 years.
3. Assistants felt that they were not recognised as a group and had nobody looking after their interests. One assistant talked of turning up at a posgraduate meeting and feeling left out as all about her the local principals were deep in discussion, no one thinking to introduce themselves.

It seems self-evident that this is a group of doctors that we should be nurturing in order to encourage high standards of care and to ensure that they do not drop out of general practice. Apart from some local initiatives,[2] it seems that this is not happening. As for the national picture, at the recent conference of local medical committees, the decision was made that GMS services should be contracted on an individual practitioner (i.e. not practice) basis,[3] thus giving health authorities no means of offering benefits to assistants from General Medical Services money.

It is small wonder that assistants as a group feel that they have been abandoned by their profession. I hope that this letter will initiate a debate in these pages to look at ways of addressing this issue vital to our profession.

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Antiplatelet therapy

Sir,

In their discussion paper (June *Journal*, p.367), Moher and Lancaster have aimed to 'provide the general practitioner with a practical guide to the use of aspirin in patients at high and low risk of occlusive vascular disease....' They are to be congratulated on a succinct review of this