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.

T R WHELAN

The Dower House
27 Pyle Street
Newport
Isle of Wight PO30 1JW

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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.

E ERNST
K L RESCH
S HILL

Department of Complementary Medicine
Postgraduate Medical School
25 Victoria Park Road
Exeter, Devon EX2 4NT

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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.

DENNIS COX

University of Cambridge Institute of Public Health
Unit of General Practice
University Forvie Site
Robinson Way
Cambridge CB2 2SR

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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