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

important and most relevant subject. The question of dosage perhaps merits some comment.

In his review, 'Aspirin as an antiplatelet drug', Patrono reached a consensus of a single loading dose of 200–300 mg followed by a daily dose of 75–100 mg 'based on findings that this dose is as clinically efficacious as higher doses and is safer than higher doses.' Given that simple recommendations are more likely to be followed, and we hope in this case on a fairly large scale, it might be reasonable to advise a single loading dose of 4 x 75mg tablets with a subsequent daily dose of 1 x 75 mg tablet. This regimen would present the minimum risk of adverse events (usually GI haemorrhage) with no evidence of reduced efficacy when compared to higher doses. In his review of the clinical pharmacology of Aspirin, Patrono points out that '...the daily administration of 30 to 50 mg of aspirin results in virtually complete suppression of platelet thromboxane biosynthesis after 7 to 10 days.' This results in the 'long-lasting functional defect in platelets, clinically detectable as a prolongation of the bleeding time.' As adverse effects are dose-related it seems wise to recommend treatment with the minimum effective dose.

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Who needs antiplatelet therapy?

Sir,

I certainly agree with the advice by Moher and Lancaster (June *Journal,* p.365) about the importance of giving aspirin to patients in the groups mentioned to prevent the risk of further myocardial infarction or stroke as far as possible.

In addition to the side-effects mentioned, I have come across tinnitus and nose-bleeds in patients on aspirin, although not on the low dose.

An unexpected benefit of aspirin therapy was a patient who developed haematuria, at first thought to be caused by the antiplatelet effect of the aspirin. Investigation revealed a previously symptomless carcinoma of the bladder.

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Data accuracy and completeness: general practitioner versus hospitals

Sir,

We read with interest the paper on the completeness and accuracy of data held on general practice computers in Scotland by Whitelaw *et al* (March *Journal,* p.181). The authors showed that, in a selected group of general practices, the data were 75% complete and were very accurate. They suggest that this compares favourably with hospital data.

We would like to point out that the Information and Statistics Division's most recent assessment of hospital data quality found 89% of main diagnoses and 86% of main operations (ICD09 and OPCS-4, at 3 digit level) to be correct in the 45–64 age group (the age range of the population assessed in Whitelaw *et al*'s study). This was based on comparisons of just over 2500 hospital discharge records (Scottish Morbidity Record (SMR1) scheme) from 42 Scottish hospitals with hospital case notes. Some of the hospitals achieved a data accuracy far in excess of the national average.

The study quoted by Whitelaw *et al* suggested 74% agreement of SMR1 with hospital case notes.[1] This was a small study performed in 1987 and there have undoubtedly been great improvements in hospital data quality since then.

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The use of antidepressants

Sir,

I was interested to read Drs John and Thakor's recent study (June *Journal,* p.363) on information distributed by FHSAs on the use of antidepressants. They suggest that the older tricyclics should be dropped as first line agents in preferences to SSRIs or Lofepramine on the basis that tolerability is approximately 6% better with the latter agents.

It needs to be pointed out that 80% of people tolerate trycyclic antidepressants entirely satisfactorily, and those that do no can simply be changed to SSRIs or Lofepramine as necessary. There are occasions when they may be as a first choice, for preferable example in individuals who are a high suicide risk or in those who are keen to avoid sedation. (I note that the study was partially sponsored by Pfizer Limited who market Sertraline.) If this were used as a first-line treatment instead of Dothiepin, the costs of treating depression would rise at least fourfold. Such a major shift in resources could only damage patient care in other areas. Obviously, this is unacceptable when there is any easy solution to the original problem and that is to use SSRIs only when necessary rather than as a first choice.

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Membership admission for the Faculty of Pre-Hospital Care

Sir,

As you are probably aware the Faculty of Pre-Hospital Care was launched in January 1996, and great interest has been shown in its endeavours and plans for the future. The Education and Assessment Committee of the Faculty Board have published the relevant academic and practical experience requirements for admission to the Faculty.

There will be an opportunity for individual assessment for admission to membership or affiliate membership of the Faculty under foundation membership clauses which will be opened until October 1996. Thereafter, admission will be strictly according to the criteria laid down by the Board.

I would be grateful if you could bring this information to the notice of your readers since there may well be a number of practitioners with many years of experience who wish to apply for admission under this special category but are unaware that this special recognition will cease in October of this year.

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