confounding factor—namely, diet—has been established by the work of Margetts and Jackson.¹ Non-smokers living with smokers are not only exposed to environmental tobacco smoke but may share the less healthy dietary practices of their spouses; thus diet may explain their increased risks of lung cancer, coronary heart disease, or other diseases.

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Safer use of traditional remedies

Clinical trials may fail to get ethical approval

EDITOR,—In his editorial on the safer use of traditional remedies David J Atherton called for "opening of channels of communication in an atmosphere less pervaded by suspicion and hostility."¹ One of the most effective approaches to reducing any existing hostility to traditional remedies would be to determine their efficacy and safety by subjecting them to scientific scrutiny in well designed clinical trials. Orthodox Western medicine may have much to gain from traditional remedies. Many modern (synthetic) pharmaceutical products have been developed from natural sources, and it should not be surprising, therefore, that traditional remedies may have beneficial therapeutic effects. Conversely, there is no reason to assume that such remedies will be intrinsically safer than synthetic pharmaceuticals, although all too often the general public tends to equate natural products with low toxicity despite considerable evidence to the contrary. It is clearly not sufficient to rely on a long history of traditional practice, with the presumption that experience has guided the selection of safe and effective constituents and dosages.

In assessing research protocols for novel synthetic pharmaceutical agents, local research ethics committees place great reliance on the expert scrutiny and assessment provided by the regulatory authorities in the form of a clinical trials certificate. As Atherton states, the Medicines Control Agency has a mechanism for licensing traditional products. Few (if any) producers of traditional medicines, however, have the resources or skill to provide comprehensive and reliable information on the provenance, quality, and safety of their products similar to that demanded for synthetic pharmaceutical agents.

Local research ethics committees have to make an informed assessment of the degree of risk and any possible benefits to patients who volunteer to participate in clinical trials. If they demanded the same standards of reassurance about safety and quality for traditional medicines that would be required for a synthetic pharmaceutical product it is hard to see how clinical trials of traditional medicines could proceed. Is it logical or desirable to apply a lower safety standard in clinical trials for traditional remedies or is there another solution?

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The preregistration period

EDITOR,—Many articles have been published on the quality of the preregistration year.¹⁻³ Most, however, concentrate on the form of the year rather than the content.

P I M Allen and B M Colls discuss how the preregistration period has been improved in New Zealand.¹ During a period of trainee internship before the preregistration year the intern is supervised by the firm's registrars and consultants under the overall responsibility of the head of the academic department. This has resulted in far more able and confident house officers. How already overworked registrars and consultants would find the time and energy to supervise an extra group of junior staff is, however, hard to imagine.

In the Netherlands medical students rotate in their preregistration period through several specialties (see table). This is comparable to the rotation of St Mary's Hospital Medical School²; the

Time spent in different specialties during preregistration period in University of Leiden, the Netherlands

	Period (weeks)
Medicine	12
Surgery and casualty	12
Neurology	6
Paediatrics	6
Psychiatry	6
Ophthalmology	3
Ear, nose, and throat surgery	3
Dermatology	3
Obstetrics and gynaecology	12
General practice	3
Occupational medicine	1

main difference is the content. As preregistration house officers are by law not doctors they are not allowed to prescribe treatment. This makes them far less liable to be used solely for service purposes. They function as the eyes and ears of more senior medical staff, see every new patient, request all the necessary tests, and make a differential diagnosis and devise a policy of treatment. When necessary, direct help and supervision are available; otherwise their findings and clinical judgment are discussed at a staff meeting in the morning or late afternoon similar to the meetings described by Bennett.⁴ These meetings have a high educational content.

This system has the advantage of a gradual introduction to clinical responsibility, which is quite different from learning your trade on a rush of adrenaline. I do not, however, have the impression that British house officers are less skilled than their Dutch colleagues—on the contrary. But they seem more run down and might consequently become less motivated in their career: motivation and fitness to practise are just as important as high clinical skills.

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SHOs unaware of new August start date

EDITOR,—The NHS Management Executive issued a directive on 4 January concerning the

introduction of compulsory induction courses for new preregistration house officers starting in post this August.¹ This entails changing the starting dates for hospital medical and dental posts. A compulsory extension of all junior doctors' contracts begins with those expecting to finish jobs on 31 July: they will now be required to remain in their present posts for the first two days of August. Trust executives have either delayed informing or failed to inform their junior staff of this directive.

Many hospital managers seem oblivious to the implications. The classified section of the *BMJ* on 5 March contained 118 advertisements for senior house officer positions starting in August. Eighty of these advertisements stated that the position started on 1 August and only 38 that it started on 3 August. According to the directive, all these posts start on 3 August.

The aim of the changes is to try to provide proper cover on the wards during induction courses and to avoid handover at weekends. This idea is to be lauded. Many hospitals already have courses in place. These courses depend on the new house staff being employed a day early.² This approach provides similar levels of ward cover and does not cause disruption for other grades.

Senior house officers constitute a nomadic tribe in the NHS, and many will have made arrangements outside the NHS. They take time out to travel and work abroad. From a distance, delaying the dates of handover may seem trivial. Many senior house officers are already committed to tenancy agreements coordinated with a changeover date of 1 August. They are still unaware that their contract has been extended to a time when they are expected to have moved out of their rented accommodation.

Unfortunately, as with so many recent NHS reforms, the directive's approach is ill conceived and it is being rushed through. The problem is compounded by poor communication, which will lead to resentment and difficulty with implementation. Medical staffing departments will be left to pick up the pieces. These changes in starting dates would cause minimal trouble if those directly affected were kept properly informed.

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- 1 NHS Management Executive. *Introduction of compulsory induction courses and changing the starting day for hospital medical and dental staff*. Leeds: NHSME, 1994. (EL/94)1.
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GP trainees and summative assessment

EDITOR,—I am disappointed by the General Medical Services Committee's rejection of the plans by the Joint Committee on Postgraduate Training for General Practice for summative assessment for general practitioner trainees.¹ The greatest weakness of British general practice is its present acceptance that the MB, BS (or its equivalent) is an adequate qualification to be a principal in general practice. If general practice is to take its rightful place as an equal among all branches of medicine it must set a higher standard for those who enter it.

The low morale of the 1960s was raised by the 1966 contract and the embryonic development of vocational training. The three year vocational training programme is far longer than previous training for doctors entering general practice. The 1990 contract has resulted in morale in general practice spiralling to its lowest for three decades. The General Medical Services Committee and