due to adhesions as a result of mesh being in contact with viscera are unknown. This contrasts with the low long term recurrence rate of less than 0.5-2%, minimal complications, and no deaths after many thousands of elective open repairs in unselected patients reported from many centres. If comparative trials are to be carried out then it is important that local anaesthesia is used for the open repair. Payne *et al.*,³ Brooks,⁴ and Rudkin and Maddern⁵ have done so, and the latter two papers favoured the open mesh technique.

Cost effectiveness must be considered. Taylor and Loosmore report on 700 laparoscopic procedures. Laparoscopic disposables cost up to about £450 a case, so £315 000 would be required. Disposables for a mesh repair are £35 and would thus amount to £24 500 for 700 repairs. This difference in costs cannot be justified.

Training surgeons in the laparoscopic technique is associated with a long learning curve and extra indirect costs. There are about 2500 general surgeons in England and Wales. I have taught experienced general surgeons the mesh techniques in a day.

Brooks concluded that the open mesh repair (with local anaesthesia) is a 'minimally invasive procedure, is appropriate for the greatest number of patients, is the least expensive and has the fewest short- and long-term complications.'⁴ Already three major hospitals in California have banned the laparoscopic hernia operation.

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Pyridoxine supplements in the carpal tunnel syndrome

EDITOR,—I confess to having started the hare that led to megadoses of pyridoxine being given in the carpal tunnel syndrome.¹ Karl Folkers visited Newcastle some 30 years ago, and when told of my recent finding that aspartate aminotransferase in necropsy tissues was only about half saturated with the coenzyme, pyridoxal phosphate, he jumped to the obvious conclusion that the subjects had been deficient in vitamin B-6. Obvious, but false. In human tissue,² rabbit tissue,³ and rat tissue (my unpublished observations) the enzyme is well saturated, but in dead or infarcted tissue the coenzyme saturation falls progressively (the rate depends on temperature and tissue—liver > heart > skeletal muscle) while the total content of holoenzyme plus apoenzyme changes little for many hours, even at 37°C (my unpublished observations). This fall in saturation happens in intact, dead or damaged tissue, not in tissue extracts: it is not due to simple physicochemical dissociation of what is an extremely stable enzyme. Whatever the mechanism—and several plausible mechanisms still survive experimental inquiry—this kind of coenzyme desaturation does not reflect the vitamin B-6 nutritional status.

The coenzyme desaturation found in plasma and red cells is likely to be due largely or wholly to processes related to the above. There is no detectable free pyridoxal phosphate in plasma⁴ since the coenzyme binds to macromolecules. At the least, then, doubt attaches to the existing supposed biochemical indicators of vitamin B-6 deficiency,

so that megadoses of pyridoxine cannot be justified by use of these indicators. Also, the doses discussed by Peter J Lewis¹ are 50 to 1000 times the usual recommended daily allowances, which may themselves be exaggerated for reasons connected with the experimental facts cited above.

This is not to say that megadoses of pyridoxine do not work: that can be established empirically, independent of virus B-6 status. It seems most unlikely, however, that the patients concerned were ever vitamin deficient.

Finally, isn't it odd to see a complementary physician recommending enormous doses of an industrially made chemical?

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Professional performance bill

Will result in doctors being suspended from register

EDITOR,—The bill going through parliament dealing with revision of the powers of the General Medical Council contains a clause that vitally affects all hospital doctors and doctors employed by health authorities. Clause 1.9 of the bill proposes that any doctor referred to the council and whom the council intends to investigate and bring before its disciplinary committee should temporarily lose his or her registration. Whether innocent or guilty, the doctor would become criminally liable if he or she continued to practise as a doctor. There are no time limits on this temporary erasure from the register.

It would be easy for any malevolent health authority or health trust to log a complaint. On receipt of a complaint from a health authority the General Medical Council's disciplinary committee is almost duty bound to order an investigation and a disciplinary hearing (one can easily visualise the outcry if a hearing was denied to a complaining health authority); the erasure would then be enacted. Suspension from the register, no matter how brief and irrespective of the reason, would enable a health authority or trust to dismiss that doctor, whose livelihood is then gone. In the past several doctors have been dismissed while temporarily suspended from the register. Usually these temporary suspensions have been for a year or so. But there is nothing to stop a determined health authority from using this process to get rid of someone whom it does not like, and there is nothing in law that a doctor will be able to do to stop it.

All this arises from clause 1.9 of the new bill. Every doctor should write to his or her member of parliament to stop the injustice of penalising doctors merely on the grounds of suspicion, before any guilt has been determined. A person used to be regarded as innocent until proved guilty, and only the guilty were punished. Apparently not any more.

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Chairman of BMA council's reply

EDITOR,—The BMA has expressed support for the new professional performance procedures and commends their objectives: to protect the public, to be remedial rather than disciplinary, and to cover doctors in all types of practices. We have several concerns about the implications of the legislation, one of which is the protection of employment rights. This has been brought to the attention of members of parliament during the progress of the bill, and we will continue to raise it during future stages of the bill in both houses. The BMA is also pursuing this issue, and others, with the Department of Health and the General Medical Council.

The intention of the legislation is that new procedures will be designed to assess a doctor's knowledge, skills, and attitudes in practice and provide remedial measures, rather than disciplinary ones, to address any deficiencies through retraining.

Clause 1, to which H Jacobs and P J Tomlin refer, relates to the new professional performance procedures and not the existing disciplinary procedures. A doctor's suspension from the register would come into effect only once the new screening and assessment procedures had taken place and then only if the new committee on professional performance thought it an appropriate course of action. Subsection (9) states that while a person's registration is suspended "he shall be treated as not being registered in the register notwithstanding that his name still appears in it."

With respect to security of employment, the bill provides that suspension of registration shall not terminate any appointment in the public service. This brings the professional performance procedure into line with the existing health procedure. Although the suspension of registration does not terminate the contract, the BMA is concerned that trusts may take independent action to terminate a doctor's contract while he or she is participating in the performance procedures: a trust might wish to avoid paying the doctor's salary and the retraining costs. This would be punitive to the doctor concerned, which is not the intention of the bill.

The BMA is seeking to ensure that the Department of Health makes arrangements whereby the services of a doctor are retained until he or she has completed the remedial procedures and is able to return to medical practice.

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Luring the vocationally trained back

Register of non-principals could help

EDITOR,—I welcome Maureen Baker and colleagues' attempt to study the increasing group of doctors who are vocationally trained in general practice but not currently practising as principals.¹ Many members of the Medical Women's Federation find themselves in this position for the reasons mentioned by the authors. We have already discussed with representatives of the General Medical Services Committee the possibility of setting up a register of "non-principals" working in general practice. This would have at least two advantages in addition to those mentioned by the authors. Firstly, difficulty in gaining access to continuing medical education is a major problem at present. Doctors who were registered could receive details of relevant educational courses and remain on mailing lists for medical newspapers and information about new drugs. Secondly, democratic representation would become feasible and could

lead to nationally agreed terms and conditions of work and much enhanced status.

We still urge all women who can to work as principals, but we recognise the need for officially recognised, short term, part time posts in general practice. Vocationally trained doctors who cannot take on the commitment that a post as a principal entails have no such option at present, and the alternatives available—assistantships, locum work, and the retainer scheme—tend to be poorly rewarded and poorly regarded. We regret the Department of Health's refusal to upgrade the retainer scheme, despite the evident need for this, and will continue to collect evidence on the scheme's use from all those interested. We would welcome correspondence on this as well as the other issues mentioned.

The need for more flexible working patterns extends throughout medicine as more women enter medicine and more men seek a better way to combine their home and working lives. Flexible working patterns and changes in ways of providing cover for out of hours services would help to maintain the health and morale of all doctors in the NHS.

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1 Baker M, Williams J, Petchey R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995;310:1301-4. (20 May.)

Payment in kind finances refresher course

EDITOR,—Maureen Baker and colleagues outline the need for a re-entry course for vocationally trained doctors who are not currently working as principals. Such a course has already been run in my practice and was enjoyed by all concerned, but no funds are currently available for this type of postgraduate training. This minor hurdle was overcome when our mature trainee offered to do several locum surgeries after the end of her course—a much appreciated gesture.

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1 Baker M, Williams J, Petchey R. GPs in principle but not in practice: a study of vocationally trained doctors not currently working as principals. *BMJ* 1995;310:1301-4. (20 May.)

Junior doctors' hours

Members of Junior Doctors Committee are in cloud cuckoo land

EDITOR,—I am sick to death of hearing about reducing hours, the intensity of work, and periods of rest. I cannot see how the Junior Doctors Committee has the nerve to recommend, in its annual report for 1995, eight hours of rest during night duty on an on call rota.¹ I would then get more sleep while on call than when I am at home and, better still, would be paid for it.

All the talk about intensity of work is rubbish. When we come to work we are expected to work and not to time how much rest we are receiving while on duty. The committee should stop moaning about working hours and get on with what it was doing before and stop pretending to be working for the greater good of junior doctors. I am not advocating long working hours. The days of over 100 hours a week are gone, and rightly. Going to the opposite extreme, however, is wrong. We must strike a happy balance between working hours and training. A 1 in 4 or a 1 in 5 rota is perfectly acceptable; partial shifts and full shifts merely

stretch out your working time, so that you end up working more nights and more weekends than on on call rotas. Half the supposed time off after duty is spent resting from previous night duties. The claim that partial or full shifts preserve your social life is not true in practice. Most of us who have worked these different shifts prefer to work on call rotas.

The members of the Junior Doctors Committee are living in cloud cuckoo land, and I wish they would stop pretending that they represent all junior doctors. Doctors have always been known to work hard and play hard, but we are now portrayed as people who constantly complain about work. What I cannot understand is why people stay in their jobs when they are so unhappy about their work. Many of us believe that the Junior Doctors Committee is ruining things rather than doing any good. The committee claims that the government ignores its calls, but the committee chooses to ignore those of us who are calling for a halt to further reductions in hours. We cannot pretend that we can still train specialists with shortened training and shortening working hours. The two simply don't mix.

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1 Junior Doctors Committee. *Annual report 1995*. London: BMA, 1995.

Reply from Junior Doctors Committee

EDITOR,—Christopher Wong is wrong to state that it is solely the Junior Doctors Committee that recommends eight hours' rest for doctors on call. This recommendation is part of the guidance on working arrangements of doctors and dentists in training¹ issued by the NHS Executive on behalf of the signatories to the heads of agreement on junior doctors' hours.² As such it represents a position endorsed by the conference of royal colleges, the Joint Consultants Committee, the Central Consultants and Specialists Committee, and the NHS Executive as well as the Junior Doctors Committee.

The question of the intensity of work is crucial to both the safety of patients and the wellbeing of all junior doctors. A great many doctors perceive the new deal as having worsened their conditions because contracted hours have been reduced without due regard to ensuring that juniors receive the rest to which they are contractually entitled: this simply means more work for less pay. Appropriate pay for the intensity of work is a high priority for the Junior Doctors Committee but must be seen as a mechanism to assist in the implementation of the new deal as it stands.

Many junior doctors perceive shift systems as not being in their interests. Yet full shift systems have been worked by juniors in accident and emergency departments for many years and have proved popular. As experience in designing shift systems that are sensitive to local requirements has increased, the number of partial shift systems worked by satisfied and well rested junior doctors has similarly increased. The Junior Doctors Committee is keen to explore with the NHS Executive how to get this message through to doctors and local management.

Many doctors continue to confuse the related but quite separate concepts of training and clinical experience. Doctors in training in the United Kingdom continue to work the longest hours in Europe.³ Yet there is no evidence that all these hours spent in training produce better specialists than elsewhere in Europe. Shortened working hours and a shortened duration of training are wholly compatible elsewhere in Europe. While this can be implemented in the United Kingdom, it will require a radical change in professional culture to

one in which the medical aspects of patients' care are delivered by fully trained specialists supported by doctors in training and not the converse arrangement, which exists at present.

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- 1 NHS Management Executive. *Junior doctors—the new deal*. London: NHSME, 1991.
- 2 Department of Health. *Heads of agreement: ministerial group on junior doctors' hours*. London: DoH, 1990.
- 3 Coshape. *Final report on the working hours of "doctors in training" in the context of directive 93/104/EC*. Brussels: European Commission Directorate General for Employment, Industrial Relations, and Social Affairs, 1994.

Multicentre studies should be cited by study name

EDITOR,—At the outset of a large European multicentre study following up children born to mothers infected with HIV it was agreed that all publications would be submitted under the authorship of the European collaborative study. This has ensured that all those participating in the study are given credit for their contribution and has avoided potential problems over authorship of individual papers. Without this approach the study could not have survived.

Recently, the study published a paper in *Pediatrics*, which included a footnote on the title page indicating those responsible for the preparation of the manuscript (the "authors") and the coordinating centre's address for reprints. The paper ended with a paragraph listing collaborators and a clearly separate paragraph titled "acknowledgements." Subsequently, requests for reprints were received at the study's coordinating centre addressed to a person whose name had been near the end of the list of acknowledgements. Only after accessing BIDS, an online reference system provided by Bath University's computing centre, did I find out what had happened. The BIDS system included as authors the last five or six people mentioned in the acknowledgements. This was not an isolated event, as on further investigation I found similar confusion in other papers published under the authorship of the European collaborative study. A Medline search confirmed the confusion, with no authors being given for the study's papers.

These errors highlight the need to develop and improve referencing systems. My preference would be to cite the European collaborative study as the author; this could then also be used in the citation index. This would permit assessment of the impact of the European study's papers and enable a researcher to obtain all papers resulting from a particular study.

The number of articles published in a particular period, the citation index, and the impact factor of the journals in which the articles are published are used as measures of academic performance, and there is pressure for clinicians and researchers to publish widely. An increasing number of multicentre studies, however, publish under group or network authorship to emphasise the multicentre nature of the work and the large number of clinicians and researchers participating. This can lead to conflict and discourage researchers from participating in multicentre studies. As coordinator of the European collaborative study, I am often required to justify a person's contribution to the study to the institution that employs that person. If the European collaborative study, instead of individual people, was regarded as the author this might help those collaborating as they could quote the standing of the study, as shown by the citation index.

With the move towards systematic reviews,