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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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.
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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,

multicentre studies, and clinical trials, appropriate referencing systems need to be developed. I propose that use of a study's name instead of named authors, with details of the writing committee and collaborators clearly stated in a footnote on the title page, is self explanatory and the most elegant solution. This would avoid confusion, facilitate the identification of papers from a particular group, and benefit the individual contributors.

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Campaign to eradicate polio is funded by charity

EDITOR,—Margaret Dooley's report on the campaign to eradicate polio does not mention that in the late 1980s the World Health Organisation was reluctant to tackle the project partly because of the cost and partly because of the problem of refrigerated transport and distribution. Rotary International spurred on the WHO by paying \$250 million for the purchase of the vaccine over five years and then providing a "cold line" through its volunteer organisation in thousands of clubs in 180 countries across the world. Only recently has Rotary been allowed to have clubs in the former Soviet Union, which is why these states are only now catching up with universal immunisation.

Rotary International planned to ensure that the world would be free of polio by its centenary year, 2005. The present rate of progress may see the goal achieved by 2000.

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1 Dooley M. Campaign targets polio "hot spots." *BMJ* 1995;310: 894. (8 April.)

Poor response to erythropoietin

EDITOR,—Iain C MacDougall's editorial on poor response to treatment with erythropoietin outlines a rational approach to this problem.¹ We agree with his scheme of how to investigate and manage patients who apparently show resistance to erythropoietin but would strongly advocate one further investigation—namely, assay of plasma erythropoietin concentrations in such patients.

We routinely assay erythropoietin concentrations in all patients receiving this treatment from our dialysis centre, including the few patients who start the treatment before starting renal replacement therapy. We use a competitive binding, disequilibrium radioimmunoassay which uses recombinant human erythropoietin for both tracer and standards and a goat polyclonal antibody to erythropoietin (EPO-Trac, INCSTAR, Stillwater, MN, USA). The assay requires overnight incubation. The primary aim of this approach is to optimise erythropoietin treatment rather than to screen for non-responders. We believe that this approach enables us to tailor the treatment to patients; in view of the cost of erythropoietin, the saving in unnecessary treatment easily covers the costs of the assay.

While using this approach we have investigated a number of non-responders. Many have had a deficiency in their erythropoietic axis, principally of iron. Importantly, we have also detected patients in whom erythropoietin concentrations have been subtherapeutic. Subsequent investigation of this group has shown either poor subcutaneous absorption or non-compliance. Use of the erythropoietin assay enabled us to avoid extensive and unnecessary investigations in this last group.

Assays of plasma concentrations of erythropoietin are a useful adjunct to the investigation of poor response to erythropoietin treatment and in selected cases will obviate more expensive and invasive investigations.

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1 MacDougall IC. Poor response to erythropoietin. *BMJ* 1995; 310:1424-5. (3 June.)

Safety of complementary medicines should be monitored

EDITOR,—As Western medicine accepts the role of complementary treatments, should not these alternatives be expected to conform to the stringent safety standards expected of orthodox drugs? We ask this in the light of three cases illustrating the toxic effects of Chinese herbal remedies.

Firstly, Kane *et al* recently reported two cases of hepatotoxicity associated with the use of herbal and plant extract remedies.¹ Secondly, we wish to report a case of fulminant hepatic failure in a 32 year old man. Four weeks before presentation he had taken a locally dispensed Chinese herbal remedy, labelled "eternal life," as treatment for simple lipomas. By five weeks he was deeply jaundiced and became encephalopathic. Despite urgent liver transplantation he died. No viral, immunological, or metabolic cause for his liver failure was identified.

Analysis of the herbal remedy that this man had taken confirmed the presence of *Dictamnus dasycarpus*; this was also identified in previous cases of herbal hepatotoxicity.^{1,2} This plant contains a wide range of potential toxins, including xanthotoxin and psoralens, along with steroid-like compounds, vasoactive substances, coumarins, and flavinoids.

We are not blind to the possible benefits of herbal remedies. But these remedies are not innocuous placebos, and we agree with the issues raised by P A G M de Smet.³ If such adverse events happened with a conventional drug, at the very least one would expect the Committee on the Safety of Medicines to be notified. In addition, the prescribing clinician and pharmaceutical company could potentially be held liable for damages. Who monitors the safety of alternative medicines? Is there any liability for their prescribing? What action can be taken when side effects occur? Are people profiting from this business without accepting responsibility for their work?

This is an important public health issue for which there seems to be no responsible representative body. Licensing is merely the first step; much more ought to be done.

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- 1 Kane JA, Kane SP, Jain S. Hepatitis induced by traditional Chinese herbs; possible toxic components. *Gut* 1995;36:146-7.
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AIDS is less of a health threat than other diseases in Africa

EDITOR,—In November 1986 the *Sunday Express* predicted that "the deadly disease AIDS is now so out of control in black Africa that whole nations of people are doomed, leaving vast areas of now populated land devoid of a single person within the next ten years." Richard Rigby's personal view about the condition of Africa in the wake of AIDS¹ is reminiscent of the newspaper's doomsday sentiment and follows another apocalyptic vision of post-AIDS Africa, in which people eke out a "hand to mouth existence in dusty, forgotten rural homes, while in the towns, industry falls silent, businesses and stores lie closed and derelict while the wind blows rubbish and old leaves down deserted dead streets."² I do not wish to underestimate the tragedy that AIDS represents for Africa, but there is something deeply disturbing about the discussion of a disease creating continental collapse when in reality it has made only a minor contribution to the enormous human suffering in Africa.

The World Health Organisation estimates that AIDS has claimed 2 million lives since the early 1980s.³ During that same period, the organisation estimates, 3.5 million people in Africa died of tuberculosis⁴ and 16.8 million people of malaria.⁵ Despite these figures, one would scour the press and scientific journals looking for predictions of continental collapse in the face of malaria or tuberculosis in vain. As a health threat AIDS is not even close to malaria and is not yet as important as tuberculosis or, indeed, measles, tetanus, pertussis, or diphtheria, which combined claim around 500 000 lives every year. I suggest that the high profile given to AIDS is more a consequence of the assumption that Africa is a continent sitting on several time bombs than a consequence of a rational assessment of the real situation.

While this is deplorable in itself, the hyperbole about AIDS is having perverse effects on the understanding and treatment of health problems in Africa. Far from AIDS being hidden among tuberculosis and other illness, as Rigby suggests, the clinical definition used to diagnose AIDS in Africa is an encouragement for established illness to be interpreted as AIDS. This helps to obscure the relation between poverty, disease, and early death and associates the cause of disease with the African propensity for fecklessness and immorality. As Larson coldly spelt it out, "African attitudes towards sexuality and marriage have undoubtedly accelerated the spread of HIV."⁶ The wringing of hands and condemnation are a familiar refrain, but the frightening consequence of millions being condemned to die of curable diseases is new.

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