novel treatments in children with acute life threatening disease might expect parents to agree to anything that might increase their child's chance of survival. Our experience shows that this is not true in all cases. Most local research ethics committees are now moving towards asking for reports of trials they have approved. It is rare, however, for them to ask about refusals to participate. Reports of trials to the committees and for publication should routinely state the proportion of people who refuse to participate and the reasons for this. This information may suggest whether patients are being properly informed, may help with study design, and might also be a means of detecting scientific fraud.

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1 Wager E, Tooley PJH, Emanuel MB, Wood SF. How to get patients' consent to enter clinical trials. *BMJ* 1995;311:734-7. (16 September.)

Information and consent forms should use short words and sentences

EDITOR,—In their article on how to get patients' consent to enter clinical trials Elizabeth Wager and colleagues mention the need for short sentences in forms that give information about consent.[1] They do not discuss the merits of using short words. The model consent form that they reproduce uses long words and phrases when short ones would easily do. It also begins by assuming literacy ("Have you read the information provided?") although many people cannot read English or speak little English and may not have been given a translated form. Forms with short words can aid oral explanations that make sense to people from a wide range of ages and abilities. Informed consent can depend as much on professionals' clear explanations as on patients' understanding.

The national forum Consumers for Ethics in Research publishes a booklet on preparing information for people who are asked to help with medical research; it suggests clear phrases to explain research concepts and techniques.[2]

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1 Wager E, Tooley PJH, Emanuel MB, Wood SJ. How to get patients' consent to enter trials. *BMJ* 1995;311:734-7. (16 September.)
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Participants should be given feedback about the trial

EDITOR,—Elizabeth Wager and colleagues have set out extremely useful guidelines for gaining patients' consent to enter clinical trials.[1] I have undertaken an anonymous, retrospective postal survey of 90 patients who participated in five trials of treatment for rheumatoid arthritis and one for ankylosing spondylitis. Seventy patients returned questionnaires (78% response rate). Most (69) thought that they had received a full explanation of the study and (67) that they had not been put under any pressure to take part, and all thought that they had been given enough time to consider taking part. Nevertheless, a considerable number (11) said that at some time during the study they wished that they had decided not to take part.

Twenty one patients could not identify the particular drug trial in which they had taken part when they looked at the names of the six drugs that were investigated (one patient ticked three of the names). Two questions concerned only those patients who had withdrawn from the study because of side effects or lack of efficacy of the study drug. Of the 24 patients who answered these questions, 19 expressed satisfaction with the resolution of their problems and subsequent treatment.

Gaining informed consent is the start of participation in a clinical trial. Results of this survey show that those who obtain consent should audit patients' assimilation of the information given them at this time. It is also important to ensure that patients are satisfied with their treatment during the study. Of the 11 patients who said that at some point they wished that they had decided not to participate, six said that this was because of side effects but five gave no reason. This suggests that researchers should be diligent in recognising uncertainties and anxieties experienced by patients and a wish to withdraw from a clinical study during its progress. The concerns of patients are not always the same as those of researchers.

Patients also reported a strong desire to have feedback about the results of the study in which they were participating. It has been recommended that patients should receive written thanks for cooperating in a study.[2] A plea has also been made for patients to be the first people to hear the results of a study.[3] Not everyone would agree with this, but it is surely right that patients are informed of the results by the investigator, preferably at the time of publication.

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Nurses could halve GP workload

EDITOR,—Keith Thompson complains that most of a general practitioner's workload consists of dealing with trivia and routine tasks (for example, cervical cytology and measurement of blood pressure).[1] I accept that general practitioners, as the public's first port of call, are likely to see many patients with minor and self limiting conditions. Patients attend the surgery because they are concerned or need advice about a problem, not to waste their general practitioner's time. What may seem to be minor or routine to the general practitioner may be of great importance to the patient. It is only general practitioners' training that enables them to recognise these minor or self limiting conditions and to reassure their patients. Furthermore, the importance of interpretation and counselling for even the most routine of procedures should not be minimised: they should be seen as a vital part of the general practitioner's workload.

The second issue arising from Thompson's letter concerns the use of nurses in general practice. The nursing profession has spent years trying to move away from performing single tasks on many patients to being involved in all the aspects of each patient's care. Nursing is a profession complementary to but separate from medicine. Nurses have different skills and should not be seen as underqualified doctors to be trained to do the tasks that general practitioners find too trivial and menial to complete themselves. I fully support the concept of nurse practitioners, but they should be seen as professionals with their own specialised role, not as cheap medical labour.

General practitioners should not underestimate their importance in dealing with minor complaints and undertaking routine procedures. They should pass on the responsibility for these matters to nurse practitioners only when to do so will improve patients' care, and having regard to the nurses' professionalism. Nurse practitioners should be allowed to apply all their skills and not be used purely as technical assistants.

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1 Thompson K. Nurses could halve GP workload. *BMJ* 1995;311: 808. (23 September.)

Training in substance abuse is lacking for GPs

EDITOR,—My practice looks after 45 patients who misuse opiates and amphetamines, for whom it has a prescribing programme.[1-3] The local police drug squad has commented that the care given to these patients has decreased the availability of heroin on the streets of north Bedfordshire. Six months ago the practice looked after more than 60 patients, and the strain of this led to the breakdown of the health of one of the partners. None of us has any training in this aspect of medicine.

After a visit by the NHS Drug Advisory Service, Bedfordshire Health has made money available for training in counselling and for support services for this work. As the leading partner in this work, I contacted the regional adviser in general practice, several treatment programmes for drug misuse, and the Institute for the Study of Drug Dependence to ask about training courses for general practitioners. I was told that no intensive short courses existed. Records showed that only two one-hour sessions were available—one of them run by me. All that was available was a part time diploma course, requiring attendance in London half a day a week for a year. As I do not wish to become a specialist in treating drug misusers, however, I cannot justify spending a whole year studying this subject intensively. The practice has as many patients with epilepsy as with drug problems, and many more with diabetes and hypertension. I do not have diplomas in any of these aspects of medicine, but I do attend courses in them. Our local drug treatment centre provides a good standard of care for the patients registered with it, but it cares for fewer patients than our practice, there is little consultant input, and it does not provide training for general practitioners.

My partners and I wish to look after our patients who misuse drugs in the same way that we look after patients with other chronic problems. The government has specifically encouraged this course of action. At the moment, however, general practitioners who treat drug misusers are flying by the seat of their pants with little support. If any problems arise the media are very ready to criticise. It seems wrong that general practitioners are encouraged to get involved in a problematic aspect of medicine when no relevant training courses are available. The only thing that keeps us going is that, as well as having 45 current drug misusers on our list, we have 28 former drug misusers. These people can be helped.

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1 Martin E. Drug addiction in general practice. The reality behind the guidelines. A discussion paper. *J R Soc Med* 1987;80: 305-7.

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Junior doctors' hours

Shift work is poisoning juniors

EDITOR,—Christopher Wong is right when he says that the current trend towards a reduction in junior doctors' working hours has gone too far.[1] Doctors have always worked long hours and were paid nothing for being on call until the 1970s, when they began to be paid some 30% of their standard pay for night duty, weekends, etc. All that was needed to improve the system was to pay more than 100% for on call duties and perhaps double on bank holidays and for uncivilised hours. I can guarantee that no doctor would complain of overwork under this system. After all, what happens now is that they do locums and so earn a similar amount in a roundabout way.

Keith Reid's reply to Wong's letter is woolly.[2] Absence of evidence is not evidence of absence, and therefore I cannot accept his point that British specialists may be no better than European specialists. If training has indeed been so bad in Britain should we let doctors who were ill trained decide what is good for junior doctors' training? To quote accident and emergency departments as successful examples of a shift system shows a lack of appreciation of the distinction between a specialty that has no beds and minimal follow up and all the major specialties, in which continuity is essential for learning. Perhaps the Junior Doctors Committee will do a trial to see how much better experiential learning is than so called structured learning, which is being thrust on an unprepared infrastructure.

Junior doctors do not dislike shift work for no reason. They like the sleep and being paid to sleep but recognise that they become nonentities in a conveyor belt health system. More importantly, their experience becomes limited because of time constraints, and learning opportunities are lost. They may never see the result of their work. Political correctness has not allowed many like me to speak out against these attempts to protect patients' and junior doctors' health, but the new system poisons the caterpillars (the juniors) so that all the butterflies that emerge will be substandard.

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1 Wong C. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)
2 Reid K. Junior doctors' hours. *BMJ* 1995;311:632. (2 September.)

Don't blame the Junior Doctors Committee

EDITOR,—As one of only a few higher surgical trainees on the Junior Doctors Committee, I have some sympathy with the views expressed recently about the quality of specialist training since the introduction of the new deal.[1-3] The quality of training may have decreased in a small proportion of units, but the authors are wrong to put the blame at the feet of the Junior Doctors Committee.

The conference of royal colleges, one of the signatories of the new deal, has stated that training requirements can be met within the package, and what Christopher Wong[1] and other junior doctors forget is that the new deal is just that—a package. If juniors in surgical specialties are being pushed towards partial shifts (often by overaggressive managers of trusts) then it is a sign that other parties are not keeping to their side of the bargain. Too many procedures are still being performed out of hours, nursing staff are not taking on full "extended role" duties, and extra consultants are not being created to provide the extended support required. If implemented properly the new deal will allow Wong to operate on most orthopaedic cases the next day yet to stay on his 1 in 4 on call rota.

What has not been pointed out is that the new deal was designed to protect patients from overworked junior staff. Tired junior doctors are dangerous—a fact that was noted by the Confidential Enquiry into Perioperative Deaths[4] yet has been ignored by the authors corresponding on this issue.[1-3] From my own surgical experience, performing repeated procedures while exhausted in the early hours does not provide as good training as performing those procedures with a clear head in the daytime and with the support of senior colleagues.

Chris Davies is wrong to presume that the Junior Doctors Committee can insist on higher rates of pay for overtime. These rates are set by the independent Doctors' and Dentists' Review Body, and the Junior Doctors Committee always provides a strong case for premium rates for overtime in its annual evidence to the review body.

The junior doctors' conference held a heated debate on training and the new deal last year. I hope that the authors will attend this year's conference on Saturday 8 June and add their grassroots opinion to what will hopefully be another informed debate on this subject.

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Committee agrees that pay for additional duty hours is derisory

EDITOR,—Chris Davis has been misinformed about the Junior Doctors Committee's policy on pay.[1] The committee shares his and his many colleagues' view that additional duty hours should be paid at at least 100% of the standard hourly rate, if not at premium rates. The committee has held this position since the inception of additional duty hours in 1992. Sadly, neither the independent review body, which suggests the rate at which additional duty hours are remunerated, nor the government, which ultimately decides this, agrees with us—hence the current derisory situation.

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Committee is split on whether to reduce senior trainees' hours

EDITOR,—Much of the recent correspondence on junior doctors' hours starts from the premise that the Junior Doctors Committee is unanimous in its determination to reduce hours.[1] This is far from the truth. At the most recent meeting of the Junior Doctors Committee, in September, a motion that I put forward—to make it the committee's official policy not to attempt to reduce the hours of senior trainees below 72 or 83 hours—was so narrowly defeated that two recounts were required.

I would echo the words of S J Krikler that doctors who believe that their views on junior doctors' hours are not adequately represented should stand for election to the committee.[1] Change can come about only from within.

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1 Junior doctors' hours [letters]. *BMJ* 1995;311:1093-4. (21 October.)

Reporting poorly performing doctors may seem an expensive waste of time

EDITOR,—If doctors are to be forced to report colleagues whom they consider to be incompetent then the exact mechanisms and procedures need to be streamlined and spelt out.[1,2] Several years ago I and two consultant colleagues became so alarmed at the standard of practice of another consultant in our unit that we approached our unit general manager and the regional health authority. Both were receptive, having had longstanding worries about the situation.

Instead of organising an inquiry the regional health authority informed us that we had to produce evidence in the form of case notes showing poor practice. This proved difficult. Opinions regarding another doctor's competence are formed in numerous ways. Presentations and comments made at clinical meetings, the practices unearthed during clinical audits, and patients who are seen jointly either because of direct referral or because of contact in an emergency all play a part. The cases that cause disquiet, however, are not recorded systematically, and finding them again can be a problem. Nevertheless, appropriate evidence was collected and supplemented by cases brought forward independently by some of the junior medical staff who had also been alarmed. The cases were reviewed by an independent assessor, who agreed with the concerns, and we were all interviewed by an eminent government medical adviser, who was also most supportive. We then awaited the disciplinary hearing.

Years passed, with our colleague suspended on full pay and the hospital served by a succession of short term locums. The hospital then became an NHS trust, and the regional health authority merged with its neighbour. On the advice of the new regional health authority the suspended consultant's contract was transferred to the trust, but assurance was given that the authority would pursue the disciplinary action. After some attention in the media the regional health authority retracted from this position, and it apparently plans no action.

The action that we took after much soul searching now seems to have been an expensive waste of time. My colleague has been suspended on full pay but without having been given an opportunity to clear his name. The hospital has been unable to employ a substantive replacement until the case is settled. I and my coaccusers feel badly let down by both the original regional health authority and its larger successor and wish that we had continued to turn a blind eye. Richard Smith refers to "changing the culture."[1] Our experience suggests that more than the culture needs to be changed, and those who are now faced with colleagues whose performance is giving cause for anxiety should seek detailed information about exactly what will ensue before they formally voice their concerns.

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