the WHO Collaborating Centre on Drug Statistics Methodology in Oslo. The collaboration of poison control centres in this work is essential. Throughout the world they receive toxicological information on plant products and other natural remedies, since they keep records of calls for help with clinical management from medical practitioners and others.

Efforts are being made by prescribers of herbal medicines within Europe to gain information on adverse reactions. An international group, the European Scientific Cooperative on Phytotherapy, supported by the European Union and coordinated by Mr Simon Mills (of the Centre for Complementary Health Studies, Exeter University), is also promoting the collection of this information.

There is a growing need to tackle this problem in Europe and North America, where phytotherapy is being used more commonly. In many other countries phytotherapy and treatment with other natural remedies are the first treatments that people use and may perhaps be the only treatments that many people can afford. It is essential to cooperate and pool information on the risks, benefits, and safe use of these preparations.

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1 Vautier G, Spiller RC. Safety of complementary medicines should be monitored. *BMJ* 1995;311:633. (2 September.)

European pilot studies are under way

EDITOR,—Guy Vautier and R C Spiller call for better monitoring of the safety of herbal remedies.[1] They are correct in identifying a serious gap in provisions. It may be helpful to elaborate on the situation and outline some steps that are being taken to improve matters.

Several hundred herbal products are available in Britain with full product licences as medicines under the terms of the Medicines Act and relevant European directives. These have to comply with tight criteria concerning quality, and their manufacturers are obliged to appoint staff to be responsible for formal pharmacovigilance duties. As almost all such products are sold over the counter, however, physicians have little opportunity to encounter them and report ill effects to the Committee on the Safety of Medicines. No other formal reporting schemes are available.

There are no mechanisms concerning safety for the much larger group of herbal remedies supplied without a licence, either in a category exempt from licensing (because they are supplied on direct personal recommendation) or by default under food safety legislation. Complaints to trading standards or environmental health officers cannot be regarded as a satisfactory safeguard for the public against products that could, especially if imported, contain almost anything.

The Centre for Complementary Health Studies is coordinating a programme funded by the European Commission to improve formal reporting schemes. This includes pilot studies in several European countries to improve the scope of conventional reports by doctors and to expand the potential for reporting by pharmacies, at least for the licensed herbal sector. Surveys will also test whether consumers' attitudes to the safety of herbal remedies affect the detection of adverse effects. Reports to pharmacovigilance centres around Europe and elsewhere will be collated centrally, and regular reports will be produced. Taken together, these projects will improve statutory safety procedures and contribute to the information available on the adverse effects of herbal remedies.

The non-licensed sector requires additional steps. The costs of a product licence are too high for such licences to be widely applied to such a diverse market, and other approaches have to be considered.[2] The primary safety concern is for the quality of the products and for guarantees that they do not contain known harmful ingredients. A registration scheme for manufacturers and for products is necessary as a minimal first step and should be based on adherence to the open procedures of good manufacturing practice and to pharmacopoeial monographs. This is a realistic goal supported by representatives of responsible suppliers such as the British Herbal Medicine Association, but it requires political will and medical support.

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1 Vautier G, Spiller RC. Safety of complementary medicines should be monitored. *BMJ* 1995;311:633. (2 September.)
2 De Smet PAGM. Should herbal medicine-like products be licensed as medicines? *BMJ* 1995;310:1023-4. (22 April.)

Depression, antidepressants, and accidents

EDITOR,—J Guy Edwards states that no epidemiological data exist to support the view that substituting newer antidepressants for older tricyclic drugs would lead to fewer accidents.[1] In a study of deaths in road traffic accidents tricyclic antidepressants were found in a low proportion of body fluids of accident victims (0·2%) compared with the proportions of such fluids containing alcohol (35%) or other drugs likely to affect the central nervous system (7·4%).[2] Further studies would certainly need to show that substitution with reversible inhibitors of monoamine oxidase A and selective serotonin reuptake inhibitors could improve on this comparatively low figure.

Section 4 of the 1988 Road Traffic Act states that "a person, who, when driving or attempting to drive a motor vehicle on a road or other public place, is unfit to drive through drink or drugs is guilty of an offence" and makes no distinction between prescribed drugs and misuse of drugs. All patients who are prescribed drugs, whether in the old or new categories, should be warned of the potential risks when driving and, indeed, when working in dangerous situations. Those patients for whom Edwards says that newer antidepressants should be considered have risk factors that probably preclude these tasks in any case.

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1 Edwards JG. Depression, antidepressants, and accidents. *BMJ* 1995;311:887-8. (7 October.)
2 Everest JT, Tunbridge RJ, Widdop B. *The incidence of drugs in road accident fatalities*. Crowthorne: Transport Research Laboratory, 1989. (TRL research report 202.)

Patients often present too late for inclusion in trials

EDITOR,—Heather Goodare and Richard Smith encourage patients to become involved in the establishment as well as the performance of clinical trials.[1] In prospective randomised controlled clinical trials in malignant disease, patients are in general well prepared to cooperate and participate. However, they must first reach the treatment centre at a time when their condition is suitable for inclusion.

The randomised controlled clinical trials of the CHART (continuous, hyperfractionated, accelerated radiotherapy) regimen of radiotherapy, in which 36 treatments are given over 12 days, were established in a cooperation between the Medical Research Council, Cancer Research Campaign, and Department of Health in 1990. Entry to the head and neck study was satisfactory, but fewer patients were submitted to the companion study in non-small cell lung cancer.

A survey of 484 patients who attended for radiotherapy for non-small cell lung cancer at 12 of the contributing centres during a three month period showed that only 24 (5%) were suitable for entry (unpublished data). The commonest causes for exclusion were poor general condition (35%), large tumour (26%), and metastases (19%).

The time course from first symptom to treatment was studied in the 484 patients. There seemed to be no undue delay by the patient reporting symptoms (median time three weeks) nor by the general practitioner referring the patient to hospital (median time to attendance at hospital four weeks). However, the median time from first symptom to diagnosis was 13 weeks and from first symptom to first treatment 19 weeks. Furthermore, in a quarter of the patients these intervals were greater than 25 and 33 weeks.

In non-small cell lung cancer, earlier diagnosis and more immediate referral for consideration of treatment may increase the number of patients suitable for inclusion in trials of radical treatment. If new methods give greater benefit, more patients will gain advantage when these methods are applied in routine practice.

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1 Goodare H, Smith R. The rights of patients in research. *BMJ* 1995;310:1277-8. (20 May.)

Local research ethics committees

Local committees have strengths too

EDITOR,—Anyone familiar with observer variation in measurement, the psychology of committees, or lunacy in the law courts would predict disagreement between research ethics committees. K G M M Alberti implies that common forms, central direction, and training will help,[1] but differences will remain. Is conformity the priority? If so, why have local committees?

The idea that research done in a community should be approved locally by a committee of medical and lay members is changing towards managed research and predictable committees. The choice of lay members is another paradox. The ideal might be a working class mother, but the need to read and argue monthly about abstruse scientific and medicolegal problems contained in about 2-3 kg of paper tends to result in members being not true laypeople but experienced members of other professions, particularly lawyers.

There is a case for unitary approval of large surveys operated through a central team, which depend on standardisation and completeness. A central committee could additionally be useful in inhibiting alleged multicentre research projects that are really promotions of products. Such a committee would have to be replicated elsewhere in Britain or be less tied to the English health service structure than Alberti's editorial suggests. Cooperative studies that entail intervention by local clinicians on patients they recruit need local consideration.

Interviewing every applicant, as Alberti implies, is beyond the capacity of committees reviewing