of proteins. Assays for total protein show poor performance in quality assurance schemes because of the diversity of methods and standards.[2] At all levels of protein excretion caused by glomerular disorders albumin is the main contributor. Albumin is a discrete protein, and specific methods for measuring it are now widely available.

Shihabi *et al* suggested that both urine total protein and albumin should be routinely estimated.[3] In our experience, in a laboratory that receives more than 2500 requests for measurement of urine protein each year, there is a linear relation between urine total protein and albumin concentrations ($r=0{\cdot}924$; $p<0{\cdot}001$). We consider that urine albumin concentration should replace total protein concentration for the assessment of glomerular proteinuria.

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NCEPOD: more training needed

EDITOR,—S J Nixon highlights the fact that the national confidential enquiry into perioperative deaths for 1990 has to report the same deficiencies as the confidential enquiry into perioperative deaths for 1985-6.[1] In surgery for the complications of peptic ulcer, deaths in 120 patients are analysed; three quarters of the patients were elderly and seriously ill, but one third were managed by an unsupervised registrar. The risks for these patients were real, while the trainees were doubly handicapped—faced with undue responsibility and denied help from a senior with whom to discuss the choice and technique of treatment. The overall perioperative mortality is rather less than 1%, but there must be concern over some of the reported deaths and other aspects of current surgical training.

Firstly, reviews of registrars' experience provide further evidence of lack of supervision in theatre.[2,3]

Secondly, a survey by the Association of Surgeons showed that training had suffered through bed closures in seven English regions. It has become difficult to learn the technique of hernia repair, with few patients being admitted and most day surgery being performed by consultants.[4]

Thirdly, theatres are now open for more limited periods and there is pressure to operate on more patients, so defter, trained surgeons do most of the work. Deprived trainees then operate on emergencies out of hours.

Fourthly, modern trends have resulted in an appreciable contraction of training opportunities in biliary and peptic ulcer surgery.

The royal surgical colleges share the vital task of inspecting and approving hospitals as suitable for training, but it is difficult to ascertain the true extent of the experience and supervision being given to trainees. The introduction of log books is a step in the right direction. The Royal Australasian College of Surgeons has taken the logical further step of requiring each hospital to submit a summary of each log book for central scrutiny, the outcome of which may be that the college requires corrective action to be taken if recognition for training is to continue.

Now is the time for the colleges to show unmistakably that service and training are distinct activities. Service currently receives nearly all the attention. Training must be accorded specific status, with a planned programme prosecuted in protected time. Managements will require facts, not opinions, about training arrangements before they will entertain change: the training committees of the colleges will have the authority to require such changes only when they can present hospitals with accurate numerical information on the quality of the experience being offered.

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Improving preregistration training

EDITOR,—Improvements in preregistration training have to start with a reduction in hours devoted to service if disabling tiredness is not to destroy educational opportunity (and endanger quality of care).[1] Hours of work can effectively be shortened while service is maintained but only if there are more people to share the work[2]: hence my proposal to double up on preregistration house officers, which would solve the problem of hours for them without the need to train more doctors. Reducing "inappropriate tasks,"[3] important though that is, cannot alone achieve this. Shift working might do it but inevitably disrupts continuity of care and educational programmes more.

Closer supervision is indeed needed at all levels of seniority[4,5] and should start at once. Much that new house staff have to learn, however, is good technique in practical procedures, basic organisation of self and others, and simple decision making (which is not as simple in practice as in theory); for all of these the best tutor is often a slightly more senior fellow apprentice who has in turn been well supervised. To introduce an apprentice partner who would not only teach but learn by teaching basic practical competence, even if for only part of the working day, would be one (but only one) of several necessary steps forward in improving supervision. To denigrate such an apprentice partner as a "proxy consultant"[6] is both to misunderstand the need and to overlook the fact that consultants are often not the most suitable people to meet it.

Well supervised training during limited hours in the front line of service needs to be complemented by withdrawal to an uninterrupted, reflective educational programme. There is much to be said for making this formal programme "common to all specialties" and for considering it to be "the first step on the road to a more integrated view of continuing education in medicine"[7] as much as the last step in general medical education. The preregistration period should become the universal joint of medical education and training.

Certainly the preregistration period, lengthened or not, needs to be seen in the context of the preceding undergraduate course, shortened or not. There could not be a better moment. The General Medical Council is at war with "pot filling,"[3,8] and most schools are now searching for a curriculum that will minimise information and maximise the ability to correlate and to solve problems.

Service hours must be shortened; supervision at all levels of skill and function must be strengthened; and an appropriate protected educational programme must be devised and implemented. It will cost money (which any responsible employer would accept as a necessary investment in its expert workforce) and effort. But radical improvement will be achieved only if continuous constructive pressure comes from the trenches: if recent graduates rise above their own justified frustration, disappointment, and even anger and use their experience and vision to help build a better future for those who follow them.

Might the Council of Deans now take the initiative and convene a small representative national group to set out a range of options for radical reform?

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Draconian sentence imposed on Vietnamese doctor

EDITOR,—Dr Nguyen Dan Que graduated with distinction from Saigon University in 1966 at the age of 24. He studied in Brussels, London, and Paris from 1967 to 1974 and was made director of Cho-Ray Hospital in Ho Chi Minh City in 1975.

He specialised in thyroid disease and diabetes and wrote 13 papers from 1975 to 1978. Gradually, however, he became critical of the low standard of health care and treatment in his country and expressed his criticism openly. Arrested in February 1978 and accused of trying to overthrow the government, he was kept in solitary confinement for several months and not given enough to eat. For two months he was kept in shackles in a cell, less than 2×2 m, without sanitary facilities. He was not put on trial but was released in 1988 after 10 years' imprisonment.

After his release the police kept his diplomas, papers, albums, diaries, and address book, and he was not allowed to practise. Nevertheless, he wrote a paper about the treatment of 17 patients with insufficient insulin. After 1988 more insulin was sent to Vietnam from abroad.

Soon after his release Dr Nguyen helped to found a non-violent political movement, whose aims included "respect for the human, civil, and property rights of the people, . . . a pluralist political system, and free elections." He was arrested again in June 1990 and held incommunicado for 18 months. He was tortured soon after his arrest. He has a gastric ulcer, which has bled twice, and he has lost much weight. His family and the public were excluded from the court that sentenced him, and he was not allowed to speak in his own defence. On 29 November last year he was sentenced to 20 years' imprisonment followed by five years' house arrest. The BBC Far Eastern Service described this as "draconian . . . by any standard."

Dr Nguyen's health is deteriorating, and he is kept under a harsh regime. If he survives until the age of 75 he will then be free. The medical group of British Amnesty has appealed to the Vietnamese government for his release and return to medical practice; it has undertaken to provide him with