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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Appointing house surgeons

SIR,—We would like to use the window of your pages to ventilate a problem which we feel must be widespread and about which many may well feel disquiet. How soon before starting the job should the appointment of a preregistration house surgeon be made?

As is the usual annual practice, we were recently invited by our local medical school to consider the arrangements for appointing house surgeons commencing duties on 1 August 1980 and 1 February 1981. Yet this was the summer of 1979. It seems that the practice of appointing junior students to their first *and second* house officer post is becoming widespread. Some medical schools appear to be fostering appointments at an even earlier stage than ours. Will it soon be that students of anatomy, physiology, and pharmacology will be expecting to have house officer commitments before the second MB has been attempted or may we expect GCE A level candidates as applicants? Inquiries made of undergraduate students, of prospective house surgeons, and of house surgeons in posts all tend to indicate that a "lead" time of some four to five months between the date of interview and the date of starting posts is adequate and preferable. We have already declined to co-operate in the current "advance buying" of medical students to commit us with house surgeons for nearly two years.

We have recently interviewed excellent candidates to start as soon as 1 February 1980. We do not find that making the selection with this sort of interval reduces the quality of our house surgeons—perhaps the reverse—but it certainly does reduce the problems of drawing out a short list.

Are we wrong, are we misinformed, or what should we be doing?

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The case-control study and retrospective controls

SIR,—We read with interest your leading article on case-control studies (13 October, p 884) and would be grateful for the opportunity to comment on a number of the points raised.

Case-control studies are described as "one of the methods of generating hypotheses and perhaps of testing them." Some groups have indeed used the case-control approach successfully for the generation of hypotheses; but clearly in these circumstances chance associations are likely to appear from time to time, which may lead to a great deal of subsequent confusion. In our opinion case-control studies are of particular value for testing hypotheses generated by clinical impression or other means.

In addition to this rather fundamental issue there are a number of points with which we would not entirely agree. We would not, for example, accept that "any retrospective study is less likely to obtain the randomness and independent selection of each individual that are found in the best prospective experimental or cohort follow-up studies." Some case-control studies have included all cases of the disease under study in a defined geographical area,[1] thus obviating this implied criticism as well as ensuring that the cases under study are "truly representative of all cases." Furthermore, it has been shown that it is often more appropriate when studying hospital cases to include as controls subjects who have also been hospitalised than those who have not been admitted to hospital.[2] We would accept that it may sometimes be useful to include a second group of "community" controls (even though this is likely to increase substantially the cost and amount of effort involved), but are unaware of any examples where the study of "at least three independent control groups" has proved helpful.

Case-control studies which have been carefully planned to eliminate as many as possible of the potential biases have not only demonstrated the association between the pill and its thromboembolic complications but number among their many other successes the first demonstration of the link between smoking and lung cancer. The problems which have been created (such as the example given concerning the unresolved debate about the possible link between reserpine and breast cancer) have usually occurred when case-control studies have been used for hypothesis generating. We do agree about the care needed in appropriate design but feel that perhaps your attitude towards this very useful epidemiological method has been rather unfairly lukewarm.

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[1] Mann, J I, Inman, W H W, and Thorogood, M, *British Medical Journal*, 1976, **2**, 445.
[2] Jick, H, and Vessey, M P, *American Journal of Epidemiology*, 1978, **1**, 107.

SIR,—After reading Dr Lawrence Cranberg's article on the use of retrospective controls (17 November, p 1265) I felt a short-lived sense of