patient's relatives it should not howl too loudly when non-medical staff inadvertently do the same.

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- 1 Beales D. Draft bill aims at improving confidentiality. *BMJ* 1994;309:360. (6 August.)
- 2 Gillon R. Confidentiality. *Philosophical medical ethics*. Chichester: John Wiley, 1986:106-12.
- 3 General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1992:26-7.
- 4 Brazier M. *Medicine, patients and the law*. Harmondsworth: Penguin, 1987:67.
- 5 Scottish Law Commission. *Mentally disabled adults: legal arrangements for managing their welfare and finances*. Edinburgh: SLC, 1991:102. (Discussion paper No 94.)

Circumcision and uncircumcision

EDITOR,—In his review of a book on "uncircumcising" Roger S Kirby is doubtful whether circumcision desensitises the glans to sexual stimuli,¹ even though many men complain that this is the case, including some who have been circumcised as adults. I am not aware of any published objective studies comparing the sensitivity of the glans in circumcised and uncircumcised men. Furthermore, although there is obvious macroscopic change in the appearance of the glans after circumcision, no published studies of the histological changes associated with this have been carried out, so far as I know. Although the profession has been performing circumcision for a century, we have never looked into its anatomical or physiological consequences. It is unwise to ignore what patients are telling us.

The fact that this book has been written should alert us to the possibility that circumcision may be more harmful than we have supposed. The knowledge that some men perceive that the function and feeling of their penis have been impaired by this operation, usually carried out in childhood without their consent and often with little or no medical indication, should concern us and stimulate further research into penile function and sensory perception. If we have no objective information about the effects of circumcision after 100 years it is hardly surprising that the profession is ignorant about the effects of uncircumcision after 10. Until this subject is properly investigated we cannot dismiss what these men report as a placebo effect and should keep an open mind.

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- 1 Kirby RS. The joy of uncircumcising! Restore your birthright and maximize sexual pleasure [book review]. *BMJ* 1994;309:679. (10 September.)

Importance of awareness of religious customs

EDITOR,—Further to A R Gatrads' article on Muslim customs surrounding death,¹ it is important that all health care workers are constantly aware of all religious customs.

A 72 year old man was sent to an accident and emergency department by his nursing home as the nurses were concerned that he had not eaten or drunk for the previous five days. He spoke no English and had no relatives or next of kin. He had lived in the home for two years, and the history was obtained from the nurses there.

On examination there were no abnormal findings. Investigations including biochemistry,

haematology, chest radiography, analysis of a midstream urine specimen, and blood culture gave negative results.

The hospital staff realised that he was hungry and gave him food, which he ate with relish. It became apparent that the nurses in the home had failed to appreciate that their patient was adhering to the requirements of Ramadan. Meals at the home were served only after sunrise and before sunset, and during the month of Ramadan Muslims must fast during daylight hours. For following his religious beliefs he had been subjected to numerous investigations and an uncomfortable night in hospital. Thus not only medical staff but also staff in institutions need to be aware of religious beliefs. Carers in institutions are often the only source of information.

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- 1 Gatrads AR. Muslim customs surrounding death, bereavement, postmortem examinations, and organ transplants. *BMJ* 1994;309:521-3. (20-27 August.)

Help for sick doctors

Confidential help is available

EDITOR,—Liam J Donaldson and Claudia Court drew attention to the important matter of sick doctors.^{1,2} They both referred to the unsympathetic attitudes of colleagues and employers when the sickness is alcohol or drug misuse.

Doctors who have an alcohol problem often live in fear of drawing attention to themselves, this fear being shared by their spouses and families. They usually do not know how and where to seek fully confidential medical help that can be trusted and regarded as safe. They fear employers and colleagues, often without cause, and they commonly most fear the General Medical Council, again probably without cause. Because of these factors the sickness may continue unaddressed, to the detriment of all concerned. This situation should not and need not arise. There is a well established way of approaching these understandable fears of discovery.

It is regrettable that neither Donaldson nor Court mentioned the British Doctors and Dentists Group, the one peer group that can and does help doctors totally confidentially and without involving outsiders. It has existed for over 20 years and is composed of a large number of formerly addicted colleagues who have been helped to recovery and thence to normal lifestyle, including being able to work professionally in happy and permanent sobriety. Help and guidance are given freely to colleagues by colleagues who are themselves former sufferers and are now free of compulsive addiction to alcohol or drugs. The group does not involve anybody outside the medical and dental professions or anybody within the professions who has not been a sufferer. In gratitude for the help that they have received group members are only too willing to share their experiences and knowledge with any newcomer who chooses to seek out the group. The success rate is high and recovery is usual.

The Doctors and Dentists Group is available to any colleague nationwide who seeks it; it fulfils one of the recommendations in the Holland report,² in that it provides every worried doctor or his or her partner or spouse with access to a confidential telephone number over which private discussion can take place.

A telephone number for any of 12 geographical areas within the United Kingdom can be obtained by using in the first instance a private number. No surnames or addresses are asked for, and calls will be taken by a doctor who has made a happy and

successful recovery and identifies himself only as "James." Call him if you think you might need help on 021 353 6817. You will receive reassurance and understanding and will be given a contact number where help can be obtained in your part of the country.

- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
- 2 Court C. British study highlights stigma of sick doctors. *BMJ* 1994;309:561-2. (3 September.)

Occupational health departments can help and be trusted

EDITOR,—On the basis of my experiences in practising occupational medicine within the NHS I agree with Liam J Donaldson's assertion that many doctors perceive occupational health departments as irrelevant to them and as having too close a relationship with management.¹ This perception stems from a basic lack of understanding about the practise of occupational medicine and occupational health and also about the workings of a modern NHS occupational health department.

Most doctors come into contact with occupational health departments only when they start a new job or when they are called for vaccinations. This is despite the fact that most departments now provide a comprehensive range of services to other members of staff. Doctors' lack of contact with occupational health departments is probably because until recently they did not fully understand their management responsibilities within a multidisciplinary organisation and were oblivious to the fact that health and safety legislation applied to them.

The lack of trust in occupational health departments may stem from the origins of such departments as nurse sick bays and it may also reflect the lack of clinical status which afflicts departments without consultant occupational physicians. That information is leaked to management, however, is totally erroneous: occupational health departments go to great lengths to protect clinical confidentiality. Perhaps this fear is based on practices elsewhere in hospitals? Occupational physicians are skilled in assessing and managing ill health in the workplace. It is sad that doctors do not feel able to consult them more often.

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- 1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)

Value of Kleihauer test

EDITOR,—Jennifer K M Duguid and Imelda Bromilow question the reliability of the Kleihauer test,¹ while Elizabeth A Letsky and Mahes de Silva suggest that a higher dose of anti-D immunoglobulin would eliminate use of the test.² We report a case showing the danger of this proposal.

A woman who was group O RhD negative delivered a baby who was group O RhD positive in 1989 and was given the standard dose of 500 IU of anti-D immunoglobulin. In her second pregnancy in 1992 screening for antibodies yielded negative results at 16 and 32 weeks; at 35 weeks intrauterine death occurred without warning. Postmortem examination attributed death to transplacental haemorrhage secondary to placental infarction. She was given 500 IU of anti-D immunoglobulin. Kleihauer testing showed over 45 fetal cells per low power field, and an additional 6000 IU of anti-D