Practical problems can be foreseen: a patient who has taken an overdose may have signed an advance directive stating "do not resuscitate," or a directive stating "I am not to be subjected to any medical treatment aimed at prolonging or sustaining life" may be found when a patient is on the operating table. Nor should it be accepted that analgesics can be used to treat thirst when simple help with nutrition will suffice.

When advance directives have been made legally enforceable, problems such as these have arisen. The doctor has been unable to treat a conscious patient who has lost the capacity to revoke the directive. As a result the patient has suffered, sometimes greatly.

The BMA's original stance on advance directives was that they should not be legally binding but should be a starting point for an improved dialogue with patients over choice of treatment. After certain judgments there has been an overhasty change. There is still, however, no mandate for the BMA's council to support the Law Commission's recommendations without widely consulting members.

There is no evidence in Britain that patients who become incompetent are being treated against their wishes or against their best interests. Nor is there any study of what the general public, as opposed to pressure groups that are seeking to advance their own agenda, really want. The original concept of a living will was introduced by Kutner in a commentary entitled "Due process of euthanasia: the living will a proposal."²

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- 1 Doyal L. Advance directives. *BMJ* 1995;310:612-3. (11 March.)
- 2 Kutner L. Due process of euthanasia: the living will a proposal. *Indiana Law Journal* 1969;XLIX:539-54.

Incompetence develops gradually

EDITOR,—Incompetence is not an all or nothing issue (as the Law Commission recognises).¹ Dementia may cause a gradual erosion of competence, and it might be difficult to decide at what point a patient lost the ability to revoke an earlier advance directive. This can be covered in a properly framed law, but we must be vigilant to make sure that the law is properly framed and that doctors are not made to face unnecessary and impossible moral and ethical dilemmas by an oversimplistic approach.

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Keyhole surgery

EDITOR,—M J Notaras may make a case for the development of specialised (perhaps private) hernia centres but fails to make any case against laparoscopic hernia repair.¹ It is true that excellent results are reported from internationally recognised hernia repair centres (although the completeness and methods of follow up do not always stand close examination). Unfortunately, however, everyday clinical reality is different. In Britain most hernias are not repaired by experts and those of us who audit hernia repairs are aware that results are far from satisfactory.

An epidemiological study of open hernia repair in a health district in Britain reported poor results, although absolute numbers of patients were not published: recurrence had occurred by three years in 31% of cases, wound infection in 14%, persistent deep sinuses in 6%, persistent pain in 16%, and

testicular atrophy in 7%, and altogether 47% of patients were dissatisfied.² Probably this represents the worst end of the spectrum, but such results may not be as atypical as we would like to think. It is incorrect to state that organ injury and death do not occur with open elective hernia repairs. They do but are rarely reported.

Laparoscopic hernia repair can be safely carried out as a day case procedure with an entirely extraperitoneal approach. True, at present general anaesthesia is required, but in our experience most patients prefer this, and local anaesthesia is not without complications. A recently published randomised trial has indicated an overall advantage for laparoscopic repair in terms of more rapid discharge and convalescence,³ and our experience of over 700 cases supports this strongly; the advantages are even more obvious for bilateral and recurrent hernia repair.

Are such trials justified? Notaras would have us believe not, but they must take place. Perhaps the opponents of trials are frightened of the results. The mere preference of a surgeon for a particular technique does not necessarily mean that it is the best. We agree that in skilled hands the Lichtenstein repair is an excellent operation, but let it be put to the test in a randomised trial against the best laparoscopic techniques.

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- 1 Notaras MJ. Keyhole surgery. *BMJ* 1995;310:871-2. (1 April.)
- 2 Devlin B. In: Katkhouda N. Treatment of bilateral hernia by open surgery—the STOPPA positional repair. In: Schumpelick V, Wantz GE, eds. *Inguinal hernia repair*. Basel: Karger, 1995.
- 3 Wilson MS, Deans GT, Brough WA. Prospective trial comparing Lichtenstein with laparoscopic tension-free mesh repair of inguinal hernia. *Br J Surg* 1995;82:274-7.

Accident and emergency radiology

"Rule of two" is outmoded and unhelpful

EDITOR,—We disagree with several parts of the "rule of twos" in Robin Touquet and colleagues' article on teaching radiology in accident and emergency medicine.¹ The authors state that when a fracture is suspected the radiograph must include the joint at either end of the long bones because of the risk of an associated dislocation or subluxation. If this practice were carried out then all radiographs of twisted ankles would include the knee and all radiographs of sprained wrists would include the elbow. This is clearly not practical or necessary. It is true that in certain instances, such as a fracture of the medial malleolus, there may be an associated fracture of the upper end of the fibula. A senior house officer should know this and carefully examine the knee, obtaining radiographs only in those cases in which there is tenderness. There is also a danger that the radiographer may be tempted to include both joints and the long bone in a single film. This results in an inadequate examination of both joints because of the divergence of the x ray beam and difficulty in getting both joints square on to the film.

It is suggested that in a child with limited extension of the elbow after injury a radiograph of the normal side should be obtained for comparison at the outset. This is an outmoded practice, and few mothers nowadays will allow an x ray examination of an unaffected limb just because the doctor does not know what normality looks like. In our department we have a book showing normal elbows at various stages of development. I cannot remember the last time we obtained a radiograph of a joint for comparison.

The authors recommend that radiographs

should be obtained before and after the removal of a foreign body in a wound. It is more sensible to remove any obvious foreign bodies, clean the wound, and then obtain a radiograph to see if any foreign bodies remain in the wound. Obtaining a radiograph of something that can be seen with the naked eye is pointless.

The rule of twos is unhelpful. It results in too many radiographs, too much radiation, and too much cost.

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Comparison view radiographs are not routinely required

EDITOR,—Robin Touquet and colleagues state that "a child with limited extension of the elbow after injury should have radiographs taken of both elbow joints for comparison at the outset."¹ This suggests that comparison views should be taken as a routine in all cases, and we take issue with this.

Firstly, this guidance is directly contrary to recommendations produced by the Royal College of Radiologists.² Secondly, contralateral radiographs are superfluous if the fracture is visible in radiographs of the affected side. Thirdly, comparable radiographs of the contralateral side are difficult to obtain. Radiographs of the affected side are often poorly positioned because of pain and swelling. If contralateral views are to be used one should ensure that the exact position of the affected side is mimicked. Fourthly, contralateral views are unnecessary if good radiological opinion is readily available. Finally, the diagnosis of subtle fractures around the elbow joint will not necessarily change the clinical management. While we agree that radiographs of the elbow in children can be difficult to interpret, we believe that the correct approach is to combine the results of clinical examination with expert radiological advice. This may occasionally result in further radiological examination being advised.

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- 1 Touquet R, Driscoll P, Nicolson D. Teaching in accident and emergency medicine: 10 commandments of accident and emergency radiology. *BMJ* 1995;310:642-5. (11 March.)
- 2 Royal College of Radiologists. *Making the best use of the department of clinical radiology: guidelines for doctors*. 2nd ed. London: Royal College of Radiologists, 1993.

Elderly people and the 1990 act

EDITOR,—Victoria Ajayi and colleagues state that "the reduction in the length of hospital stay is consistent with the findings that after the legislation patients were more likely to be in hospital for rehabilitation than awaiting placement."¹ Our experience in Edinburgh seems to confirm this finding.

Since 1988 we have carried out five surveys to monitor the prevalence of elderly patients awaiting placements for long stay care in our general hospitals. The first two surveys were reported in 1992² and the results of the last three surveys have

been submitted for publication. Figure 1 shows that the proportion of elderly patients awaiting placement has fallen over the period of the surveys and that the rate of fall has increased since 1993.

FIG 1—Percentage of patients waiting for long term care 1988-94

FIG 2—Percentage of patients waiting for different types of long term care

We have also seen dramatic shifts in the distribution of changes: figure 2 shows that, whereas in 1988, 8.5% of patients waiting for long term care were waiting for private nursing home places, in 1994 this increased to 61.6%. Conversely, those waiting for NHS geriatric long stay care fell from 75% in 1988 to 12.8% in 1994.

Our experience suggests that the major factor in the reduction of length of stay, at least in Edinburgh, has been the faster placement of patients into private nursing homes. The apparent increase in rehabilitation patients suggested by Ajayi and colleagues may not be real but due to the decrease in the number of people waiting for long stay care.

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1 Ajayi V, Miskelly F, Walton I. The NHS and Community Care Act 1990: is it a success for elderly people? *BMJ* 1995;310:439. (18 February.)

2 Namdaran F, Burnet C, Munroe S. Bed blocking in Edinburgh hospitals. *Health Bulletin* 1992;50:223-7.

Medical schools and racial discrimination

EDITOR,—Nigel Turner is correct in saying that "selection criteria for medical education should be based on a rigorous analysis of what makes for the best possible doctors for the future."¹ We have been working towards just such evidence based selection criteria for 15 years, as have many others world wide, and still have a long way to go. Our contention is that until agreed and valid criteria can be measured and extracted from any application

form we need a pragmatic approach to immediate improvement.

One of several measures that we proposed in our paper in the interests of all applicants would be to anonymise applications at the initial shortlisting stage²; this is a feasible proposition similar, for example, to the procedures used now with examination scripts in most universities. Fairness at interview does not seem to be a problem either for entry to medical school³ or in the training grades³—the difficulty is to get an interview.⁴

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1 Turner N. Medical schools and racial discrimination. *BMJ* 1995;310:1532. (10 June.)

2 McManus IC, Richards P, Winder BC, Sproston KA, Styles V. Medical school applicants from ethnic minority groups: identifying if and when they are disadvantaged. *BMJ* 1995; 310:496-500. (25 February.)

3 McKeigue PM, Richards JDM, Richards P. Effects of discrimination by sex and race on the early careers of British medical graduates during 1981-7. *BMJ* 1990;301:961-4.

4 Esmail A, Everington S. Racial discrimination against doctors from ethnic minorities. *BMJ* 1993;306:691-2.

Treating mental health problems in health care workers

EDITOR,—I am the registrar who was working in the Bethlem Royal Hospital unit treating mental health problems in health care professionals until the time of its closure. I take issue with Sue Stevens's suggestion that it is no more embarrassing for health care professionals to seek treatment for mental illness or psychological problems than for any other section of the community.¹

Many health care professionals live within the catchment area of the hospitals where they work, and entirely routine admission would entail treatment by people who are friends, enemies, or colleagues but not the disinterested professionals experienced by everyone else. A normal doctor-patient relationship cannot be established under such circumstances, and the quality of care given may be only marginally better than self care or no care at all.

In recognition of this, many of the patients who were admitted to the unit at the Bethlem Royal Hospital had previously been placed by the responsible trust in other trusts' wards or, at considerable expense, in private facilities. Although this removed the problems of the patients being treated by personal acquaintances, the quality of care given was compromised because medical and nursing staff were unsure whether to treat the person as a patient or a professional, the development of a proper doctor-patient relationship being impeded by this. Any doctor or nurse admitted to hospital for any reason will be familiar with this phenomenon and the accompanying dangerous deviations from orthodox practice that can result. The effect is in proportion to the seniority of the patient and is particularly damaging in psychiatric practice, where the treatments have been developed for use in a doctor-patient and not a doctor-colleague relationship.

Health care professionals need specialist treatment facilities because not everyone is as egalitarian as Sue Stevens. Although she might believe that all patients, professional or otherwise, ought to be treated identically, this simply does not occur. Just as many women would not want to be the only woman on a ward of 30 patients, so a doctor does not want to be the only health care professional. Both feel that their status is not something that they can help—and in an ideal world would make no difference—but both feel uncomfortable because the world is not ideal. Consequently, care suffers. For example, a

psychiatrist whose depression has been triggered by one of his patients having coincidentally died after a session of electroconvulsive therapy might have difficulty sharing this burden with other patients on a standard ward but could do so in a unit for sick health care professionals.

Closing the unit for sick health care professionals condemns one section of society to care that is likely to be less pleasant and therapeutically inferior to that experienced by the rest. This, also, should raise serious questions.

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Failing sick doctors

National Counselling Service for Sick Doctors offers support and help

EDITOR,—My colleagues and I are distressed to hear of the difficulties experienced by Martin S Wolfson in seeking help for a colleague.¹ The National Counselling Service for Sick Doctors was set up to meet exactly the situation described—that is, when a doctor seems to have a problem that may impair his or her performance and future health but seems unable or unwilling to seek treatment.

A colleague, close relative, or the doctor concerned can contact the service (telephone 0171 935 5982) and, without providing any further information, will be given the name and telephone number of a national adviser, usually from the same branch of medicine. That adviser will have the delicate task of making contact with the doctor who is giving rise to concern and identifying whether a problem exists and whether the doctor is receiving appropriate help. Remarkably, most doctors approached are willing to discuss their situation and will usually accept an offer of further help. If appropriate, this may take the form of contact with a psychiatric counsellor approved by the Royal College of Psychiatrists or referral to another service.

None of my colleagues can understand why Wolfson was not dealt with in this way. Though the telephone line is a dedicated line, it is in another organisation; just possibly, a well meaning person answered it when none of the committed staff were available. We have sent our apologies to Wolfson and have invited him to contact us again.

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British Doctors' and Dentists' Group will provide an intervention service from 1 July

EDITOR,—Martin S Wolfson's letter about his attempt to take action over a doctor with alcohol problems comes as no surprise.¹ A report of the Nuffield Provincial Hospitals Trust clearly outlines the failure of systems that purport to be in place.² The British Doctors' and Dentists' Group, which has existed for over 20 years, provides confidential help for chemically dependent doctors. We have a membership of roughly 800 recovering doctors and dentists. We can arrange admission to clinics that specialise in the treatment of this disease and also provide long term support for families and the recovering doctors and dentists. About 80% of our members return to full time work in worthwhile appointments either as consultants or in general practice.