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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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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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.