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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- 1 Stevens S. Treating mental health problems in health care workers. *BMJ* 1995;310:1010. (15 April.)

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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- 1 Wolfson MS. Failing sick doctors. *BMJ* 1995;310:527. (25 February.)

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.

We have a close working relationship with the Medical Council for Alcoholism, which refers colleagues in difficulty directly to us. We have 15 groups meeting regularly throughout England, Scotland, Wales, Northern Ireland, and the Republic of Ireland. Our experience with existing systems is similar to that of Wolfson; some of my colleagues have taken four years to contact the group before any active treatment for their disease was undertaken. Chemical dependency ultimately kills, and it behoves us as a caring profession to have a duty of care towards our afflicted colleagues and, not least, their patients.

Some of the members of the British Doctors' and Dentists' Group have set up an intervention service for chemically dependent doctors, which in many ways will be similar to the dentists' intervention scheme, which has proved extremely effective and successful. This scheme will be in operation from 1 July and will be staffed by recovering chemically dependent doctors on a nationwide basis. The national helpline number will be announced before that date, but in the meantime my contact number is 01252 316976. Any inquiries will be treated with the utmost confidentiality.

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- 1 Wolfson MS. Failing sick doctors. *BMJ* 1995;310:527. (25 February.)
- 2 Silvester S, Allen H, Withey C, Morgan M, Holland WW. *The provision of medical services to sick doctors. A conspiracy of friendliness.* London: Nuffield Provincial Hospitals Trust, 1994.

FHSA's or health commission's medical adviser can support and advise

EDITOR,—I suggest that the medical adviser of Martin S Wolfson's family health services authority or health commission is well able to offer sympathetic support and advice regarding his concern about a doctor with alcohol problems.¹ The medical adviser is also able to facilitate medical care and locum arrangements and is usually able to visit and test how true the rumour and innuendos are.

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- 1 Wolfson MS. Failing sick doctors. *BMJ* 1995;310:527. (25 February.)

Treatment in the air

EDITOR,—Recent reports in the press of a woman's experience during a flight from Hong Kong to Britain made fascinating reading. When she developed symptoms and signs of a tension pneumothorax as a result of a road traffic accident that day she received lifesaving treatment from Professor Angus Wallace and Dr Tom Wong, who inserted a makeshift chest drain.^{1,2} This was fashioned from a urinary catheter, some oxygen tubing, a bottle of water, and copious quantities of sticky tape. A skin incision was made with a scalpel, and the catheter was stiffened with a coat hanger to facilitate insertion. All the equipment was "sterilised" in brandy. Although these actions certainly saved the traveller's life, we question some aspects of the management.

No suggestion was made to land the plane or decrease its altitude from 10 000 m. Increasing the ambient air pressure would reduce the size of the pneumothorax and thus its haemodynamic and ventilatory effects. Thus the first action in this situation should be to request an increase in cabin pressure and descent to a lower altitude, with the plane being landed at sea level if possible.

The current management recommended by a

large proportion of the profession, including the Advanced Trauma Life Support Group, would simply be to insert a hypodermic needle or intravenous cannula through the anterior chest wall of the affected side. This would successfully decompress the tension pneumothorax and hence be life saving. This, in combination with oxygen treatment, an increase in cabin pressure, and rapid transfer to hospital would expose the patient to least risk.

We believe that the need for a chest drain is questionable, particularly when the equipment and situation are suboptimal. Insertion of a chest drain can be hazardous. Complications such as contusion of the lung and damage to intercostal vessels, with life threatening haemorrhage, can occur and may be difficult to treat. Damage to major vessels and the mediastinum are also reported.

It is easy to make comments in retrospect, and we have no wish to detract from the skill and courage shown by Professor Wallace and Dr Wong in saving this traveller's life. We wish to point out, however, that there are potentially safer methods of managing this situation should it arise again.

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- 1 Laurance J, Young R. Jumbo jet surgeon tells how he saved tourist at 35 000 ft. *Times* 1995 May 24:5.
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Trust withdraws allegations against consultant

Trust fostered traditional gender culture

EDITOR,—On 30 May the Royal Cornwall Hospitals Trust withdrew its charges against Dr Helena Daly. A settlement was reached whereby the trust agreed that its case against her was unfair and her dismissal wrong; her credibility as a doctor was restored, but she was not reinstated.¹ This was a hollow victory as far as her patients were concerned.

On the advice of her barristers Dr Daly gave up her fight for her post because she could see that if none of the hospital managers would support her reinstatement she would be unable to function as a doctor. Her appraisal of a return to work without due regard for internal tensions was reinforced by Dr Helen Zeitlin's case: soon after her reinstatement Dr Zeitlin resigned because she felt she was subjected to the same treatment that had precipitated her original tribunal.

The real problem that Dr Daly presented arose because of her commitment to work and her patients. Most of the charges against Dr Daly were minor and commonplace; more importantly, however, they were the result of the reactions of staff being asked to raise standards and expectations. Dr Daly was not a whistleblower but she could well have been—she was shaking up a system in need of improvement. The record of care and management in Truro is not a good one: this is the trust's fourth public case this year. All cases demonstrate the problem of isolated autonomous hospitals.

NHS managers should acknowledge the effect that a mismatch of cultures can have on morale and relationships; their role is to understand conflict and resolve staff difficulties. It is a pity that a well thought out re-entry package for Dr Daly could not have been agreed which would have addressed the needs and attitudes of staff, patients, and Dr Daly.

The BMA's legal department has supported Dr Daly throughout, but in future doctors should be reinstated, not just win a moral victory. I hope that a teaching hospital will recognise a good doctor and appoint Dr Daly. But what of Cornwall's health services? It comes as no surprise that some of Dr Daly's patients are now travelling to London for treatment; this is surely a costly way of compensating for the poor way in which this case has been handled. On the assumption that the secretary of state ratifies this settlement, the Department of Health has some responsibility for ensuring better practices and accountability within the Royal Cornwall Hospitals Trust, making certain that Dr Daly is not disadvantaged in her search for a consultant post, and informing trusts of her potential for any NHS employer.

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- 1 Dyer O. Trust withdraws allegations against consultant. *BMJ* 1995;310:1486-7. (10 June.)

Suspension was waste of talent

EDITOR,—The Royal Cornwall Hospitals Trust has agreed to withdraw all allegations against Dr Helena Daly and accepted that the evidence given at her original internal inquiry was "unreliable."¹ The process has kept Dr Daly, who is a talented and well qualified haematologist, away from her patients for almost three years. It has also resulted in a climate that has made it extremely difficult for her to return to work in the place where she had made her home and where she was supported by her patients, who are devastated by this outcome.

Her case shows that the procedures used to discipline and dismiss doctors in the NHS are still a problem. In 1985, when I was unfairly suspended, my lawyers argued that suspension should be an emergency procedure used only if there was a threat to the wellbeing of patients,² yet the procedure is still being used quite wrongly.³

Medical directors have little experience compared with regional medical officers and have less standing than chief executives and trust boards. In Dr Daly's case the trust charged her with personal misconduct, which meant that she would have no right of appeal under paragraph 190 of the terms and conditions of service. She fought against this, using paragraph 190(d), and the secretary of state upheld her right to an appeal in February 1995 as the charges (now admitted to be unfair), had they been proved, would have amounted to professional misconduct. Another doctor has been vindicated yet has had her working life totally disrupted. Surely it is time for proper consultation about this secretive, badly managed, and wasteful process.

Dr Daly now has to find another consultant post. I hope that the profession will join together to redress the wrong done to her and ensure that the trust's admission that the action taken against her was unfair and that her clinical work was excellent is not undermined by gossip. Surely justice demands that, just as the General Medical Council restores to the register those who have served a jail sentence for criminal behaviour (as her locum in Truro has done), those who have been the victims of unfair dismissal should also be able to work in their chosen profession with the respect and cooperation of their colleagues.

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