the possibility that his cheating was a silent revolt against the inadequacy of the course or of his teachers. The wise lecturer always notes if his or her audience is sleeping—it is a sure sign of a bad, boring, or useless lecture. Was Jack's cheating another version of the sleeping student?

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1 Leavitt FJ. Cheating at medical school. *BMJ* 1995;310:1014-5. (15 April.)

Lying statement reinforces in appropriate cultural stereotype

EDITOR,—This year we celebrate the 50th anniversary of the defeat of the racially inspired policies of Nazi Germany. It is therefore particularly surprising and disappointing to find an article from Israel, of all places, which contains the statement that "people of some Middle Eastern cultures see little wrong with lying." The author, Frank J Leavitt, should make it clear to readers which groups he is referring to (Israeli, Palestinian, Jordanian, etc) and the scientific evidence on which his statement is based. The editor of the *BMJ* should also make clear whether, on reflection, it is appropriate for such racist comments to be published in the journal.

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1 Leavitt FJ. Cheating at medical school. *BMJ* 1995;310:1014-5. (15 April.)

Medical students cheated in the past too

EDITOR,—Frank J Leavitt describes his soul searching when deciding to mark down a medical student guilty of plagiarism.¹ The comforting thought had arisen that the student had wanted to have some means of escape from medicine, which may indeed have been so. An entry dated 27 October 1883 in the minutes of the medical college, in the archives of St Bartholomew's Hospital, suggests that is not always the case:

A letter as to Mr Matthew Souvielle from Dr William Osler of Montreal was read and a letter from Mr Matthew Souvielle in reply was also read. As Mr Souvielle admitted what Dr Osler asserted amongst other matters, that he had endeavoured to obtain a degree at the University of Erlangen by a fraudulent thesis it was resolved that Mr M Souvielle be not permitted to enter to the practice of this Hospital and that as his term of admission to the dissection room has expired, he be not permitted to enter the school.

This student's fraud had concealed a desire not to leave the profession but to continue in it. Discovery in one place had involved further deception abroad. What later scientific or medical frauds might have resulted had Osler not intervened—and had the authorities at St Bartholomew's not taken it on themselves to maintain academic standards—can only be speculated on. Leavitt can take comfort from the fact that Osler—and all others who take active steps to combat medical or academic fraud—would support his decision.

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1 Leavitt FJ. Cheating in medical school. *BMJ* 1995;310:1014-5. (15 April.)

Author's reply

EDITOR,—I was particularly distressed by John A Thomson's failure to read my words carefully and to see that I was praising the student's Middle

Eastern culture, in contrast to that of some northern Europeans, like the followers of the German philosopher Kant, who might be sticklers for fine points of "absolute truth" while failing in kindness, forgiveness, and caring for the lives of their fellow humans. As I made clear in what I wrote, I seriously considered overlooking the student's cheating for this reason, but I rejected the idea for reasons of medical ethics. The student is a Jewish Israeli, as am I. We both fully belong to the same non-Western culture. Only a lack of familiarity with our culture can have led Thomson to call my remarks "racist."

For clarity I should add that Judaism can be quite lenient with respect to a well intentioned lie—to spare someone's feelings, for example. And a number of authorities in Jewish medical ethics will approve of a doctor lying to a patient with a terminal illness to spare the patient mental distress. But these matters are different from fraudulent deception, which cannot be accepted.

This student, as I said, "was one of the sharpest and most enthusiastic participants in class discussion." So I do not think that this particular case was a case of "silent revolt against the inadequacy of the course or of his teachers," as G T Watts suggests. But Watts is right to suggest this possibility, which had not occurred to me. Just as a poor grade means that we failed at getting the material across, so cheating may indicate a serious flaw in our teaching. I will have to re-examine my teaching. And I must thank Watts for this.

Ruth Richardson's historical comment is interesting, but I wonder whether printing the student's name was not a violation of his privacy.

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Careers advice for medical undergraduates

EDITOR,—The provision of careers advice to medical undergraduates seems an obvious necessity. This will become even more important with the new changes to the curriculum (of "core plus options") because students will not get as broad an exposure to specialties.

We are medical students in our final year at the University of Leeds and have for a long time been concerned at the lack of guidance on careers available in medicine. Until recently, there was no careers advice at all. Students and junior doctors with sufficient nous would perhaps approach a senior in a specialty in which they were interested. Such advice, however, would obviously be biased. For many doctors, choice of career seems anecdotally to have been based on chance or hearsay or on their drifting through specialties at senior house officer level.

We believe that objective, formalised careers advice should be available to undergraduates and junior doctors, parallel to that provided for non-medical undergraduates by the university careers services. This should be as broad as possible, covering the various medical specialties, including management, pharmaceutical industry, journalism, and so on, as well as the more conventional areas. We have suggested that a resource room should be made available, and information from the royal colleges, the BMA, and the careers section of the *Student BMJ*, along with details of relevant postgraduate courses worldwide, would form a useful beginning. Perhaps it would also be helpful to have brief statements from a variety of consultants and professors on how they got where they are and what was useful and not in the course of their careers.

An interesting precedent has already been set in

Leeds. Historically, the law department used to deal with careers itself. Now the careers service caters for law undergraduates, and advice given even includes advice on legal specialisation. Perhaps the same could happen with medicine. Proposals along these lines were regarded favourably by the dean and postgraduate dean at Leeds, and recently a regular careers fair has been introduced. We would be interested to hear what other hospitals and medical schools have available for their staff.

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Australia needs an organisation for victims of medical accidents

EDITOR,—It is interesting to see how the improvement in patients' ability to obtain compensation for medical negligence in Australia is triggering the same initial response as was provoked in Britain when work by Action for Victims of Medical Accidents started to have an appreciable effect.¹ In Britain, too, doctors talked of the dice being loaded against the doctor when the opposite was—and, sadly, still is—true. The difficulty in financing an action and finding a competent lawyer and sympathetic medical experts and, finally, the enormous hurdle of the Bolam test ensures that patients have a small chance of succeeding in a medical negligence action. (In the case of *Bolam v Friern Hospital Management Committee* negligence was defined as failure to come up to the accepted standard of medicine as evidenced by a responsible body of medical opinion.^{2,3}) For example, while over four fifths of ordinary actions for personal injury are successful, less than half of actions for medical negligence succeed. In addition, doctors accused patients of damaging the health service by claiming compensation, when the blame lay with the accidents resulting from unacceptable practice and the reluctance of the health carers to address that issue.

Fortunately, the emphasis now seems to have been altered in Britain. We hear less of the complaints and more of the need to address the real problem through initiatives, such as the management of risk, audit, and evidence based medicine; these initiatives should improve standards and thereby reduce accidents and, incidentally, litigation. Perhaps Australia needs an organisation such as Action for Victims of Medical Accidents to concentrate minds.

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1 Chapman S. "The first thing we do, let's kill the lawyers." *BMJ* 1995;310:1090. (29 April.)

2 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

3 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

Advice to authors

We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.