clinical negligence, and hence costs, or at least to moderate the expected increase in them.² These costs, of precaution and administration, as well as of accidents themselves, will not all fall necessarily on the NHS, let alone on any one purchaser or provider. Overall minimisation of NHS costs would require some restriction on expenditures for the actual and possible victims of accidents. Court awards may be contested, settlement offers reduced or delayed, or clinical precautions stop short of the maximum possible, for example.

Until NHS organisations always prioritise minimisation of overall costs borne by victims of medical accidents, even at the expense of the NHS budget, pressures on resources mean that there is no guarantee that victims will retain even their current standing among NHS priorities for resources.

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1 Harris J. The injustice of compensation for victims of medical accidents. *BMJ* 1997;314:1821-3. (21 June.)

2 NHS Executive. *Clinical negligence costs*. London: Department of Health, 1996. (FDL (96) 39.)

Compensation should be analogous to prompt payment of a bill

EDITOR—There seem to be two logical lapses in Harris's article on the injustice of compensation for victims of medical accidents.¹ Firstly, the courts do not award compensation for medical "accidents." In the vast majority of cases, compensation is not awarded unless the victim can show that he or she has suffered from negligence—that the treatment given has been greatly below the standard to be expected. A medical "accident" that occurs in the context of adequate skill and care will not attract compensation. Secondly, it is specious to suggest that people claiming compensation should be assessed as competitors for healthcare resources. They are not asking for health care but are requiring prompt payment of a bill that the courts have allowed them to submit. If they have to wait then so should the electricity company, the plumbers, the caterers, etc—perhaps even the lawyers who conducted the hospital's defence.

I am attracted to one possible extrapolation of Harris's philosophy. Might we establish a system whereby hospital managers have to enter a waiting list scheme, so that their bonuses and salaries are not paid until other healthcare priorities have been met? Of course, sufficient interim payments would be awarded to alleviate real hardship, though not to cover unnecessary luxuries, just as Harris suggests priority should be given to compensation claims for ongoing care rather than for mere pain and suffering.

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1 Harris J. The injustice of compensation for victims of medical accidents. *BMJ* 1997;314:1821-3. (21 June.)

Health system must take responsibility for unjustly harming patients

EDITOR—I agree with Harris that there is much about compensation that is unfair, but I disagree about the reasons why it is unfair.¹ I would also suggest that compensation is already rationed. One recognised means of rationing is the use of waiting lists, and the average time to judgment in claims for compensation is five to seven years. Compensation is also already rationed by the limited financial access of many plaintiffs to the legal system.

Harris argues that compensation should be treated similarly to health need. We should not confuse justice with clinical need after an adverse event. People may have huge clinical needs after an event but no case because of lack of proof or absence of true negligence. Alternatively, people may have a clear need for justice because they have been gravely harmed by the system, either by negligence or by error, although they may or may not be left with severe health needs. The health system does at times unjustly harm patients, and it should take responsibility for this in some way. Our society currently sees this responsibility in terms of money.

To pretend that the litigation system is about attending to health needs in a fair way is a fallacy, and proving the essentially legal (not medical) term of negligence can be a lottery. No fault compensation could address much of the task of fairly meeting people's health needs after an adverse event, but the key question remains: what part has justice to play in this? People are harmed by excellent health care where no one has been at fault; should they be compensated the same as those whose care or carers have been negligent or just in error? I fear a system in which responsibility (which is not the same as blame) is removed entirely.

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1 Harris J. The injustice of compensation for victims of medical accidents. *BMJ* 1997;314:1821-3. (21 June.)

Benefits of an honest admission

Occupational health services aim to deliver proper care

EDITOR—Those who work in occupational health in the NHS will have been dismayed by the personal view about a doctor's ordeal after a needle and syringe were found in his on call flat.¹ The occupational health department's poor communication with the anonymous author—who had a history of mild bipolar disorder—is open to criticism, but in defence of the occupational physician, the fact that a domestic assistant finds a full syringe in an on call flat might raise the possibility of self medication or substance misuse.

From this experience the author castigates occupational health services in general and draws the wrong conclusion. It is untrue

to suggest that nurses or any other health professional with "a whiff of mental illness will be filtered out." The case of Beverley Allitt—a nurse who was found guilty of harming and murdering children in her care—prompted a review of procedures but not a purge of those with mental illness. Given the high prevalence of psychiatric morbidity in healthcare workers,² such a policy would be nonsensical, besides potentially falling foul of the Disability Discrimination Act. The reality is that the published rate of NHS staff being found unfit from all causes at pre-employment health assessment is 0.7%.³ There are no blanket rules regarding mental illness, and each case is assessed individually. The suggestion that doctors should fabricate their medical histories is misguided and goes directly against recent advice from the General Medical Council.⁴

Doctors have particular problems in managing their health, especially if it affects their work. The temptation to self prescribe or engage in casual "corridor consultations" has been noted and deprecated.⁵ Anxieties over confidentiality within the small world of medicine can deter doctors from seeking help when appropriate, and some may not even register with a general practitioner. Occupational health services are not in the business of weeding out sick doctors and rendering them unemployable. Above all, the aim is to ensure that they receive proper care, take sick leave if necessary (often against the interests of their employer), are supported and rehabilitated, and remain fit for work. Doctors should be encouraged to register with a general practitioner and use primary healthcare services like other patients do. Similarly, they should use occupational health services like non-medical staff do. It would be a pity if this article deterred doctors from seeking help from services that genuinely wish to improve their lot.

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1 The danger of honest admission. *BMJ* 1997;315:195-6. (19 July.)

2 Caplan RP. Stress, anxiety, and depression in hospital consultants, general practitioners, and senior health service managers. *BMJ* 1994;309:1261-3.

3 Whitaker S, Aw T-C. Audit of pre-employment assessments by occupational health departments in the National Health Service. *Occup Med* 1995;45:75-80.

4 General Medical Council. *Good medical practice*. London: GMC, 1995.

5 McKeivitt C, Morgan M, Simpson J, Holland W. *Doctors' health and needs for services*. London: Nuffield Provincial Hospitals Trust, 1996.

Doctors should declare relevant medical details

EDITOR—I was dismayed to read the anonymous personal view entitled "The danger of an honest admission."¹ As a result of his experience, the author has been left with a poor and biased view of the role of occupational health services. The picture portrayed should not be considered typical.

Occupational physicians are impartial, professional advisers who have a responsibility

ity to both employee and employer and an ethical duty to put the interests of their patients first.² In the case of an NHS trust, the occupational physician's obligation to the employer is to ensure that an employee does not have a medical problem that poses a health and safety risk to the employee, patients, or other members of staff. When assessing an individual's fitness to work the physician must also consider the level of skill and physical and mental capacity required for effective performance of the work, as well as any possible adverse effects of the work, or the work environment, on the employee's health.³

An audit of all 700 pre-employment questionnaires completed by doctors starting work at Southmead NHS Trust between 1 July 1993 and 30 June 1996 showed that 16 doctors declared a history of mental health problems. Of these, seven were contacted by an occupational health nurse by telephone or seen in person, six were contacted by the consultant occupational physician by telephone, and three were seen by the consultant in person. Strategies for preventing or reducing the work related element were discussed with the nine doctors who indicated that their problems were work related. All 16 of the doctors were assessed as medically fit to work in the job that they had applied for. One doctor had a relapse of her condition, but after a month off work she returned to her post. Two doctors referred themselves back to the occupational health department. One of them, at his request, was referred for counselling, and the other requested detailed careers advice and an appointment was made for her to see the postgraduate dean.

Job applicants should be encouraged to declare relevant medical problems on occupational health questionnaires. By providing confidential, independent medical advice and support, occupational health departments can work in the best interests of all members of staff, the general public, and, most importantly, individual employees with health problems.

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- 1 The danger of an honest admission. *BMJ* 1997;315:195-6. (19 July.)
- 2 Faculty of Occupational Medicine of Royal College of Physicians. *Guidance on ethics for occupational physicians*. 4th ed. London: RCP, 1993.
- 3 Royal College of Physicians of London and Faculty of Occupational Medicine. *Fitness to work: the medical aspects*. 2nd ed. Oxford: Oxford Medical, 1995.

Career guidance for doctors

RCSE is doing much to help surgical trainees and medical students

EDITOR—Carnall says that career advice for doctors can be hard to come by.¹ He may be correct, but I can assure him that the situation is improving.

It is unusual to find surgical trainees disillusioned, but many are confused about the changes in training, and they are often uncertain about how they should proceed.

The Royal College of Surgeons of Edinburgh has taken the need for career advice seriously. For final year medical students we have written and distributed the booklet "Becoming a Surgeon," which describes the pathways to becoming a trained surgeon. We exhibit at the medical school career fairs and have developed a career advisory service, which responds to the needs of medical students as well as surgical trainees. Each year more than 1000 surgical senior house officers receive a brochure from the college describing the new training. Those who register with us receive not only advice and help on structured learning but have the opportunity to correspond with and visit the college for help. Our booklet "Choosing a Surgical Specialty," which explains the higher surgical specialty options, also assures our trainees that a departure from the traditional career path is not a disadvantage and that interview committees appreciate candidates with diverse range of talents.

Carnall is correct that not all consultants are skilled in appraisal or in counselling. Our course "Educating consultants" is designed to help trainers improve these qualities. All our fellows in the United Kingdom recently received literature on how they can make the most of their training opportunities. We say that one of the motivations for a lifetime of enjoyable surgery is to see confidence grow in young doctors as skills develop and a career begins to blossom. We try to make sure that career information is accessible where it is needed. It is available on the internet ([http://www/rcsed.ac.uk](http://www.rcsed.ac.uk)) and also by post.

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- 1 Carnall D. Career guidance for doctors. *BMJ* 1997;315:6. (5 July.)

Career counselling has to be part of appraisal

EDITOR—Carnall's editorial on career guidance and recent letters in response to Smith's editorial on problem doctors show the wide range of advice and support that doctors currently need.¹⁻⁴ As part of this support, the Standing Committee on Postgraduate Medical and Dental Education has recommended the introduction of appraisal for doctors and dentists in training. Its 1996 working paper for consultation clarified the purposes of, and distinctions between, appraisal, assessment, and performance review.⁵ There is still tremendous confusion about the meaning of these terms and unhelpful variability in their use.

In the standing committee's view, supported by the vast majority of those responding to the consultation, appraisal for doctors and dentists in training should be primarily educational, totally confidential except in defined eventualities, and designed to help the trainee to progress. In contrast, assessments, which are also an important part of postgraduate education, are needed to inform the regulatory process about career progress. They should be objective

and open and subject to appeal. Both appraisal and assessment contain elements of performance review, but they need to be kept separate. This presents challenges to hard pressed consultants and trainees, who must find protected time to carry them out.

Unlike Smith,⁴ the Standing Committee on Postgraduate Medical and Dental Education considers that career counselling has to be part of appraisal because appraisal is a tool to help career development. Appraisal should therefore not just be confined to feedback on performance in a particular post. Doctors will draw on many inputs when making decisions about their careers and professional lives, a process that the committee has termed continuing professional development. This and other forms of support, including mentoring, are the subject of inquiries by the standing committee, and reports will be submitted shortly to the secretary of state for health.

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- 1 Carnall D. Career guidance for doctors. *BMJ* 1997;315:6. (5 July.)
- 2 Bennet G. All doctors are problem doctors. *BMJ* 1997;314:1908. (28 June.)
- 3 Noble BA. All doctors are problem doctors. *BMJ* 1997;314:1908. (28 June.)
- 4 Smith R. All doctors are problem doctors. *BMJ* 1997;314:841-2. (22 March.)
- 5 Standing Committee on Postgraduate Medical and Dental Education. *Appraising doctors and dentists in training*. London: SCOPME, 1996.

Payment of financial incentives to GPs may invalidate informed consent process

EDITOR—The fraud committed by Dr John Anderton¹ was not academic fraud, as in other recent cases, but financial fraud inspired by the large payments now made by drug companies to doctors to enter patients in trials. Within hospital departments this income is usually put into research funds, but in general practice the doctor is often personally remunerated. This is now sufficiently lucrative that some general practitioners have reduced their clinical work and set up companies to administer trials and the proceeds. The ethical issues involved, particularly relating to informed consent, have yet to be properly debated by the profession.

Although drug company trials are often of high quality in terms of design and scientific method, their primary purpose is commercial. The companies design the trials, collect the data, analyse them, and (sometimes) publish the results. The doctors entering patients have no scientific input, gain no professional credit, have no knowledge of the results or their interpretation, and play no part in the publication process. The only interest they have is financial. Effectively the doctor's status is bought by the company to legitimise the trial to the patient.

When consenting to a trial patients believe that their doctor is personally involved in scientific inquiry for the com-