dedicated service for addicted doctors is now long overdue.

Three distinct components of care are essential. Firstly, entry routes into treatment should be simple and well publicised and must include crisis intervention. Responding to a crisis such as police proceedings or exposure at work with a distant appointment is manifestly inadequate. Not only is it compassionate to offer urgent admission; it is also valuable to capitalise on the motivation generated by the crisis.

Secondly, though immediate admission for assessment and detoxification is desirable, existing addiction units often have major difficulties in providing this care. Doctors who have committed crimes and other acts shameful to their professional standing may have difficulty sharing these episodes with a non-medical peer group. Other patients may express outrage at a fellow patient who is a doctor. The addict-doctor may therefore need treatment in a dedicated unit—probably alongside other addicted healthcare professionals.

Thirdly, special arrangements for supervision and post-treatment monitoring are essential, especially if the recovering addict-doctor returns to work. Progress may need to be “policed” by a supervising consultant in liaison with the recovering doctor’s employer or senior colleagues. Support systems such as peer groups⁸ and counselling are pivotal factors in maintaining recovery.⁹ Monitoring should include random collection of supervised urine or hair samples for analysis¹⁰ and should generally continue for some two years.

The phenomenon of the addicted doctor may shock and offend. Nevertheless, it must be addressed by both the profession and employers as an important cause of impaired performance through ill health. In America, state level “impaired physician” schemes^{7 11 12} ensure that addicted doctors are confronted, receive adequate treatment, and return to work under supervision. Other countries may feel less comfortable with such interventions, but, as the BMA report illustrates,¹ greater professional awareness at all levels and visible dedicated services will enable many doctors to avoid the tragic consequences of drug and alcohol dependence that can so affect their patients, their family, and their careers. The current lack of a dedicated

service leaves many addicted doctors unchallenged, untreated, and abandoned: the BMA report’s failure to deal with comment on this point is an important shortcoming in an otherwise excellent document. With good outcomes from treatment of this group (on whose training so much has already been expended), there are compelling grounds for such a development. The addicted doctor, the profession, and the general public would all benefit.

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Turbulent future for school nursing and health visiting

Change the bathwater—but hang on to the baby

The government is attempting to reduce inequalities in health by public health measures rather than by a fundamental redistribution of wealth.¹ Primary prevention and health promotion will be encouraged and health action zones will “provide more integrated care ... better housing, healthy schools, and healthy workplaces.”² In the light of this, the recent proposal by Cambridge and Huntingdon Health Authority to move resources from health visiting and school nursing into acute care may seem perverse. Of course, health authorities must consider cost effectiveness, but it seems shortsighted to sacrifice pri-

mary prevention and health promotion to pay for technology and acute services.

What do health visitors and school nurses do, and how effective is it? The health visitor’s first task is to identify health care needs. Together with general practitioners, they provide the child health surveillance programme of immunisations, screening, and advice. They aim to identify those important conditions that parents might overlook and, for the rest, to help parents access professional expertise, voluntary agencies, and local facilities.³ Britain’s child health surveillance programme is already the leanest in the

BMJ 1998;316:406-7

Western world, and several screening procedures have been discontinued following evidence based reviews.⁴

Health visitors increasingly prioritise their caseload. They prevent and treat postnatal depression, which may adversely affect child development; they promote immunisation, breastfeeding, good nutrition, and dental care; and they contribute to the prevention of sudden infant death and home accidents. Research in America has shown an impressive cost benefit ratio for health visiting, but data in Britain are sparse.⁵ Monitoring and intervention are essential for registered cases of child abuse, but are probably a less effective use of resources than primary prevention by family support. Health visiting offers the greatest potential among parents suffering severe deprivation and stress, who often lack the emotional and material resources to deal with issues such as stopping smoking or coping with depression. The challenge is to identify these mothers, secure their trust, and offer them a service that is not provided for everyone without them feeling stigmatised.

The first step in achieving this should be a better distribution of health visitors. Middle class areas do not need the same proportion of health visitors as areas of high deprivation.⁶ Targeting communities or neighbourhoods is more effective and less stigmatising than targeting individuals. Next, the visiting pattern should be reviewed. A trusting relationship between client and health visitor is more likely if contact is made before the baby is 10 days old, and antenatal contact is probably even more effective.⁷ Enabling a family to decide what help they require needs at least two visits, as specified in the basic child health surveillance programme, but contact beyond this should form part of a programme of care with defined objectives.

Two other developments might increase the effectiveness of health visiting. Firstly, an idea proposed 20 years ago—the combination of preventive health care and home based primary nursing care for children—should be tested.⁸ Secondly, health visitors could promote the health of their local community by increasing their public health role, identifying population needs as well as those of individuals. To strengthen networks for socially isolated families, health visitors should call on the full range of local community services: they do not have to solve all their clients' problems themselves. Campaigning and working with local agencies on environmental hazards, poor housing, and child care should pay dividends, though maintaining the link between individual and public health work is important. A new approach to community data collection that emphasises outcomes, rather than counting contacts, is urgently needed.

School nurses too are doing some soul searching. School entry medical examinations by doctors have been replaced by health interviews with school nurses, but there is little evidence on the value of this exercise, except perhaps where preschool medical care is poor.⁹ The school health service must collaborate more closely with primary care and focus on today's health problems—promoting physical and mental health, supporting children with physical or intellectual impairments, and reducing school failure due to missed learning disorders, bullying, or depression. Education about high risk behaviour and helping children to build self esteem and a successful school career should be joint responsibilities of education and health services.¹⁰

No healthcare activity can escape cost containment measures unless it produces robust evidence of effectiveness.¹¹ Much progress has been made recently in calculating the costs and benefits of screening programmes. Health promotion measures are harder to assess but, as evidence of what works accumulates, opportunities for successful intervention will increase. School nurses and health visitors must expect to compete with other professions for the important public health tasks of the next decade, but they have served the community well and deserve support for retraining and professional development.¹²

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Caring for patients with chronic leg ulcer

Early specialist assessment offers the best hope of sustained healing

Leg ulcers are common, disabling, resistant to treatment, and expensive to manage. There is debate, not just about how to treat them but where. Recently, the trend has been towards treating patients almost exclusively in the community, leaving it to trained community nurses armed with evidence

based protocols and pocket Doppler devices. The diversion of resources away from specialist care in hospitals, as well as being politically motivated, has been driven by clinical trials showing that community treatment can work: ulcer healing rates can improve as much as 70% over 3-6 months when care is provided